OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24

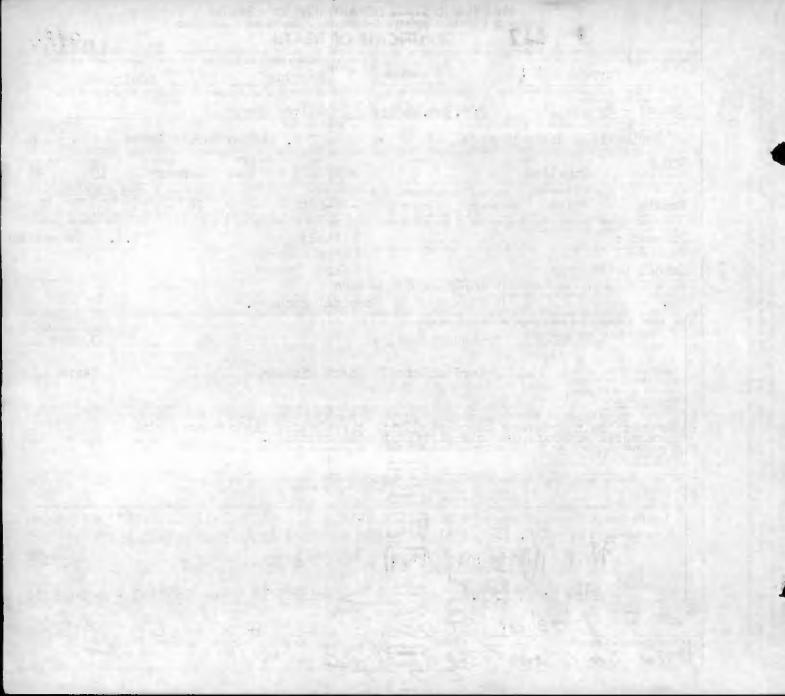
TO HOSP

VR A15 (4) 15M 9/59

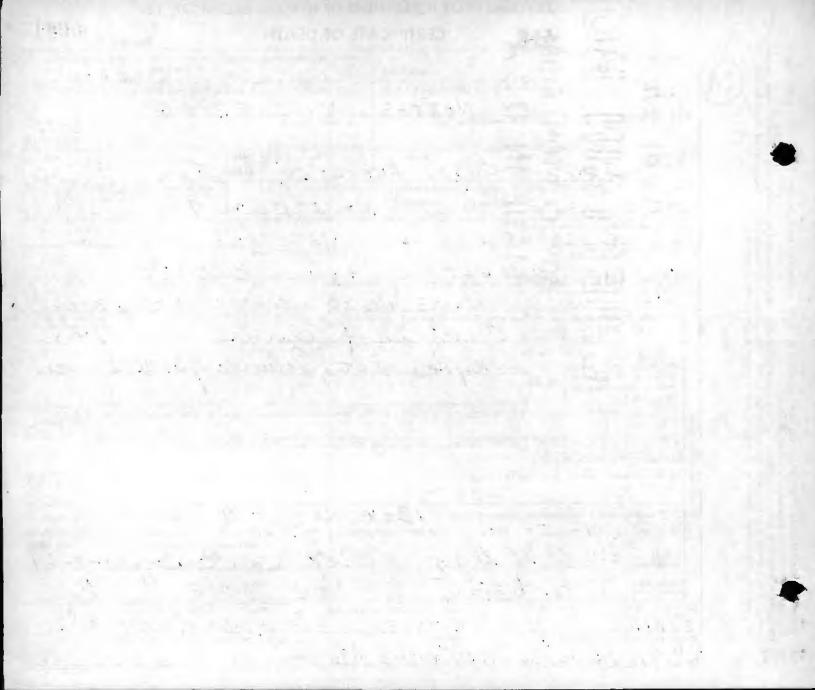
s after death. Page 4

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CEPTIFICATE OF DEATH

	21	- 6	CERTIFICA	AIE OF	DEATH				1.1	1415
a. COUNTY	arroll		MARYLAND	O STATE	Maryla:		d lived, If institution b. COUNTY	on: Residen		/
RURAL and give no	If autside carporate limi earest town) Sykesville		r.3mo.16day		Silver	_	prote limits, write R	URAL and	give near	rest tawn)
d. NAME OF HOSPI	TAL (If not in hospital, a	ive street addr	ess)	d. STREE	T ADDRESS		Spring 1	Drive		ON A FARM?
NAME OF DECEASED (Type or print)	Angelina Angelina		Middle	AGRI	ESTI	4. DATE OF DEATH	Janua		Doy 19	Year 19 61
Female	6. COLOR OR RACE	7. MARRIED	DIVORCED	5-26-			9. AGE (In years lost bighday) O yrs.	IF UNDER Manths	1 YEAR Doys	IF UNDER 24 HRS. Hours Min.
during most of work Housewife	ON (Give kind of work king life, even if relired	dane 10b. KIN	O OF BUSINESS OR INC		HPLACE (State	e ar fareign c	ountry)			WHATCOUNTRY? Naturalize
Samuel De	lVecchio				ie Sta					
NAS DECEASED EVE	R IN U. S. ARMED FOR (If yes, give war or doles of s	CES? 16. SOC	IAL SECURITY NO. 17.	Hospita	l reco	rds.	Add	ress		
	immediate (Bron Arte	r (a), (b), ond (c).] nchopneumon: eriosclerot		Disea	se			ONSI	ears
Chronic cerebra	brain syndr	ome ass cleros	TRIBUTING TO DEATH B SOCIATED WIT S WITH DSYC E HOW INJURY OCCUR	th circu	latory	distu	rbance, 1		T 1(a) 19	P. WAS AUTOPSY PERFORMED? YES NO
Hour o. m.	RY Month, Day, Ye	ar 20d. INJUI While of work	Nat while	PLACE OF INJUI factory, street, a	RY (Hame, farr ffice bldg., etc	m, 20f. (Cit c.)	or town)	(6	Caunty)	(Stote)
1	sed alive an Jan	18 m	the deceased from 1961, and that	M.D. ATTENI PHYS. 22d. AE	DING NO DORESS	AM, fram	STAFF PHYS.	nd an the	e date	stated above. 22b.DATE 1-19-01
Bo. BURIAL, CREMATIC REMOVAL (Specify	1 / 22		ST Draw	OR CREMATOR			ate Hosp		- Sy	(Stote)
FUNERAL DIRECTOR		is:	ADDRESS SOO H She	7 n.E	250 PEC	D BY REGIS		STRAR'S SI		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



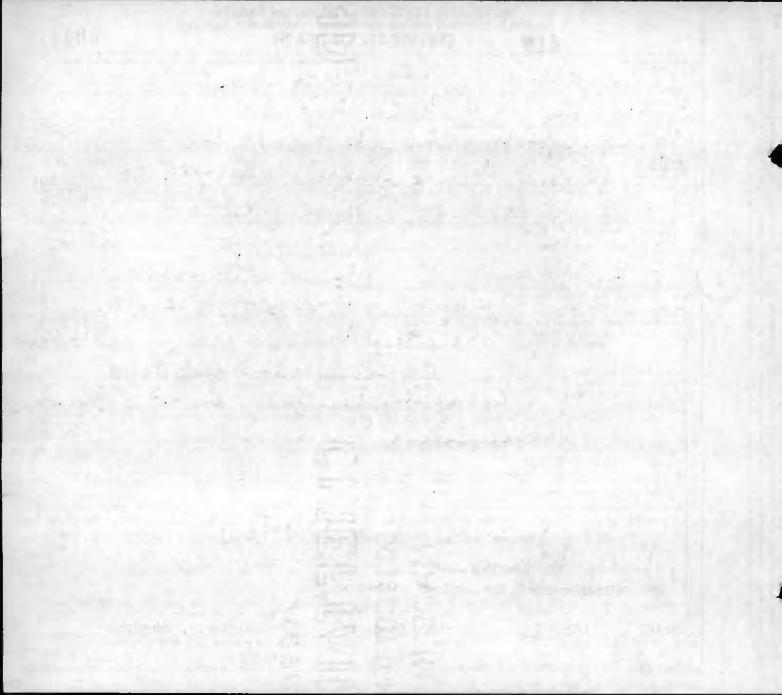
419

after death. Page 4

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24

VR A15 (4) 1SM 9/59

VI)	1	o. COUNTY	ursll	MAR	YLAND Q. STAT	Mary Soul	b. COUNTY	-
		RURAL and give no		TIBY OF STATE	9/	OR TOWN (If outside corporate li	mits, write RURAL and giv	3 VOI. 4
515		d. NAME OF HOSPIT	AL (If not in hospital, give	no moits	d d. STREE	Trauth St	ment	e. IS RESIDENCE ON A FARM? YES NO
		NAME OF DECEASED (Type or print)	(Victor)	St. S. Middle	(Andreae)	Lost OF DEATH	min 22	Day Year
	S.	SEX	1 40	MARRIED NEVER MARR	200	187H		YEAR IF UNDER 24 HRS. oys Hours Min.
	10c	dyring most of work	ON (Give kind of work dane king life, even if retired)	106. KIND OF BUSINESS	OR INDUSTRY 11. 8IRT	HPLACE (State or foreign country	12. CITIZE	NOF WHAT COUNTRY?
T	13.	FATHER'S NAME	. Derdrea	4	14. MOTH	DULLE JA	uloan	
0	(Ye		R IN U. S. ARMED FORCES'		D. 17, INFORMANT	omite	Address Detond	~
		420.	ATH (Enter only one couse ATH WAS CAUSED 87: IMMEDIATE CAUSE (o) DUE TO	per life for (o), (b), and (Tenai los	outhof h	anous.	INTERVAL BETWEEN
	NO	Conditions, if a gove rise to i couse (a), stating lying cause lost. Part II. O'll	mmediate DUE TO	CONSTRIBUTING TO D	EATH BUT NOT RELATED	TO THATERMINAL DISEASE CON	NOITION GIVEN IN PART	(d) 19. WAS AUTOPSY PERFORMED?
2	CERTIFICATI	20g. ACCIDENT WA	AS UNDERLYING [] 20b	DESCRIBE HOW INJURY	OCCURRED. (Enter notu	of injury in Port I or Part II of	item 18.)	YES NO
	MEDICAL		Y Month, Doy, Year	20d. INJURY OCCURRED While Not while at work	20e. PLACE OF INJU factory, street, o	RY (Home, form, 20f. (City or to	own) (Co	unty) (Stote)
			ot (I) (this hospital) o	E) / / /			couses and on the	that (1) (we) last
		220 GIGNATURE	1.0	Maroky	M.D. ATTENI PHYS.	DING MED. ST	AFF IYS.	22b. DATE SIGNED
- 1		MAROTA I	izankowsk)		State Hosp:	it		
7		REMOVAL (Specify) Burial	1/25/61	Western	Cemetery	Baltimo	1	
RA	24.	n Lick	s signature	ADDRESS 12	md.	DATE JAN 2 3 '61	25b. REGISTRAR'S SIGN	



MARYLAND STATE DEPARTMENT OF HEALTH

. IS RESIDENCE ON A FARM?

YES NO 3

IF UNDER 24 HRS.

12. CITIZEN OF WHAT COUNTRY?

INTERVAL BETWEEN ONSET AND DEATH

3 weeks

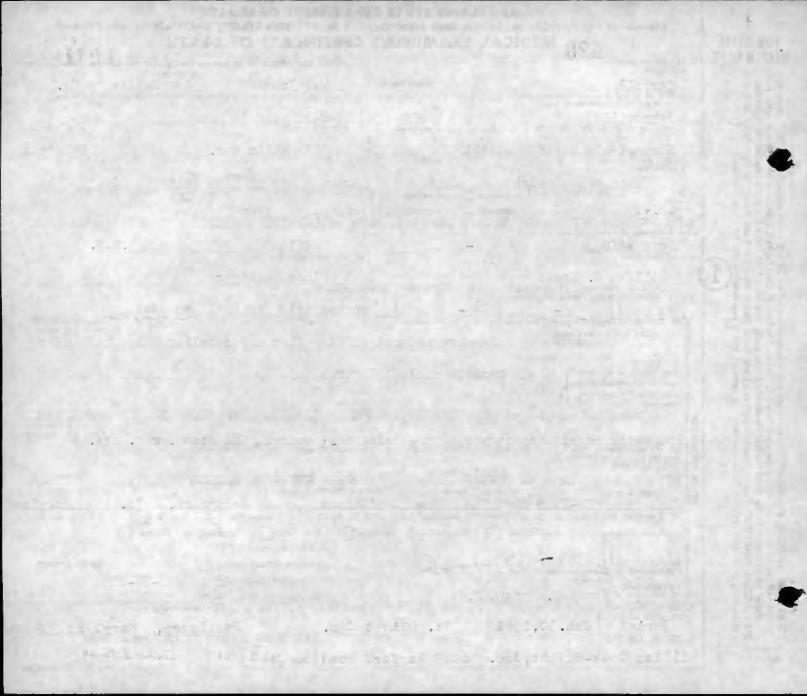
PERFORMED?

(Stata)

DATE SIGNED

U.S.A.

(County)



MARYLAND STATE DEPARTED BALTIMORE 1, M. KICA

1	12	A	-2	
	G	4	ì	[]
U	U.	2	A.	. 2

421	CERTIFICA	TE OF DEATH	66419
1. PLACE OF DEATH o. COUNTY	MARYLAND		PINTY
Carroll		Maryland	Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If outside corporate limits,	write RURAL and give nearest town)
d. NAME OF HOSPITAL (If not in hospital, give street	et oddress)	Westminster d. STREET ADDRESS	e. IS RESIDENCI
R.F.D. #Bute # 1		R.F.D Route # 1	ON A FARM
3. NAME OF DECEASED (Type or plat)	Disa T	Paro Lost 4. DATE OF BEATH DAY	Month Day Year
1 1 1 1 1 1	RRIED I E ER MARRIED	GE (In fost birth	hdoy) Months Days Hours Mir
10a. USUAL OCCUPATION (Give kind of work done 10 during most of working life, even if retired)	A-A		12. CITIZEN OF WHAT COUNT
Retired Homemaker			
13. FATHER'S NAME		Harford County	
Inma- D 17-133			
James B. Wakeland	6. SOCIAL SECURITY NO. 17. IN	Susan ?	Address
(Yes, no, or unknown) (If yes, give war or dates of service)	a. SOCIAL SECORITI NO. 17. III		
No	Mr	James R. Bailey Same	
1B. CAUSE OF DEATH [Enter only one couse per	line for (o) (b), and (c).]	7 10	ONSET AND DEAT
PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)	erlocal	- Instrum	3 14 4
DUE TO		2007	
Conditions, if ony, which)	= 1000	Alevasor	AL BARNO
gove rise to immediate	AULAUT.		The state of the
couse (o), stoting the under.			
lying couse lost. (c)			
20g. ACCIDENT WAS UNDERLYING 20b. D OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	CONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMINAL DISEASE CONDITI	ON GIVEN IN PART 1(0) 19. WAS AUTOP
E 20a. ACCIDENT WAS UNDERLYING ☐ 20b. D	ESCRIBE HOW INJURY OCCURRE	. (Enter nature of injury in Part I or Part II of item	The state of the s
OR CONTRIBUTING CAUSE OF DEATH			
	INTURN OCCURRED 20- 81	ACE OF INJURY (Home, farm, 20f. (City or town)	(County) (Sto
Hour p. m. Whi	1	tory, street, office bldg., etc.}	(County) (3rd
p. m. 19 of w	ork ot work		
21. I certify that (1) (this haspital) after	nded the deceased from	11 M 2 125 710 Sa	15. 19.6 , that (I) (we) I
saw the deceased alive and	A 11	edth accurred of fram the cau	ses and an the date stated abo
22o. SIGNATURS	7 dila mar d	The decorred digital wall like each	22b. DAT
9 Maria	and Dead	A.D. PHYS. D MED. STAFF	SIGN
22c. PHYSICIAN'S	Muchae	22d, ADDRESS &	X
NAME (TYPE DREIRE	Se WIKEN	5 15 Kemberaha	Mahma
23g. BURIAL, CREMATION, 23b. DATE THEREOF	23c. NAME OF CEMETERY O	R CREMATORY 23d, LOCATION (City,	. town, or county) (State)
Burial 1/18/61	Woodlawn	Woodlawn	, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS		b. REGISTRAR'S SIGNATURE
If Alleshamile	1271 11	JAN 1 7 '61	arthur J. Through

VR A1S (4) 15M 9/59

Harrist Louis Pitcher Comment of to the father of the state of wind in the stable to a state of the Simply the way to the world the way of the same of the The state of the state of the state of 4 - 1 MAN STILL BOOK TO The same was for the same of t

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH may be red by the hospital or afterding physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, crematian, or remayal, and in any event within 72 thours after death. ofter death. Page 4

60420

PLACE OF DEAT	H			1	2 USUAL RESIDENCE (V	Where decease		n: Residence	before admis	sion)
a. COUNTY	arroll		MARYL	LAND	o. STATE	rland_	b. COUNTY	Bali	to.City	7 1
	'N (If outside corpora re nearest town)	te limits, write	c LENGTH OF STAY	IN 1b	c. CITY OR TOWN (II	f autside corpo	orate limits, write Ri	JRAL and giv	ve nearest fow a	n)
Sykesv			11mos.170	days	Baltim	nore 18			101	agent &
d. NAME OF HO	SPITAL (If not in hosp	oitat, give stree	et address)		d. STREET ADDRESS	4206 (Charlcote	Road		SIDENCE A FARM?
Spring	field Sta	te Hosp	ital		3870031	X28888			YES [
3. NAME OF DECEASED		First	Middle		Lost	4. DATE OF	Mon	th	Day	Year
(Type or print)		James	Warner		Bandel Bandel	DEATH	Janu	ary	17.	19 61
S. SEX	6. COLOR OR	RACE 7. MAI	RRIED NEVER MARRIE	D 💽 B	. DATE OF BIRTH		9. AGE (In years last_birthday)		YEAR IF UND	ER 24 HRS
Male	White	WIDOV	WED DIVORCED		October 18,	1875	85 yrı.	/MOISINS D	ays Hours	PVIII.
10a USUAL OCCUP	ATION (Give kind of	work done 10	b. KIND OF BUSINESS OF	R INDUST	RY 11. BIRTHPLACE (SIO	te or foreign	country)	12. CITIZI	EN OF WHAT	COUNTRY
Office	worker	I	8.80. Railro	ad	Maryland	l		U,	S.A.	
13. FATHER'S NAME	W.				14. MOTHER'S MAIDEN	NAME				
Frankl	in/Bandel				Alice/Wa	rner				
15. WAS DECEASED [Yes, no. or unknown]	EVER IN U. S. ARME		6. SOCIAL SECURITY NO.	17 INI	Charles C	Simos	on 107 Add	na Vie	w Aven	ne
No			None	1	Charles C Springfield	Hospi	tal Recor	dsA	nnapol	
1B. CAUSE OF	DEATH [Enter only	one couse per	line for (o), (b), and (c)-]]					INTERVAL B	ETWEEN
PART I.	DEATH WAS CAUSE	D BY: USE (a)	Bronchopneu	moni	a				Days	
4.	1 1	UE TO								
Conditions,	if ony, which)	(b)	Arterioscle	roti	c heart dise	ease			Years	s.
_	o immediate D	UE TO								
lying cause I	ost.	(c)	Generalized	art	eriosclerosi	is.			Year:	S
Z D PATE	OTHER SIGNIFICAN	T CONDITIONS	CONTRIBUTING TO DEA	TH BUT	NOT RELATED TO THE TER	MINAL DISEA	SE COND TION GIV	EN IN PART	1(a) 19 WAS	ALTOPSY
C.B.S.a	220C.MT.OII	seurre	brain disea	ase v	Aron bayenor	ic rea	culon.		YES] NO 5
200 ACCIDENT	TWAS UNDERLYING TING CAUSE OF E TIFY MEDICAL EXAM	EATH	ESCRIBE HOW INJURY OF	CCURRED	. (Enter nature of injury i	in Part I or Po	rt il of item 18.)			
	NJURY Month, Do	y, Year 20d	INJURY OCCURRED		CE OF INJURY (Home, fo		y or town)	(Co	ounity)	(State
20c. TIME OF IN	m.	19 Whi	e Not while	foct	ory, street, office bldg., (etc.)				
			nded the deceased	E	[an 30)	1060 40	Januame 1	7 10 67	that (I)	/\ 1
			y_161%1 and		*		_	*		
22a SIGNATUI		<u> manuar</u>	A-TOISOT vaua	ingi d	earn accorred dis	A M, Iram	the couses on	a un me		
ag	retin	del	Compo.		ATTENDING PHYS	MED. DIRECTOR	STAFF PHYS X		1/17/	26 DATE SIGNEI 61
NAME MY		delCa	mpo, M.D.		Springfie	ld Hos	pital,Syk	esvil	Le,Md.	
23a. BURIAL, CREM	ATION, 236 DATE 1	THEREOF	23c NAME OF CEME	ETERY OF	CREMATORY	23d LOCA	ATION (City, town,	or county)	(Sto	ote]
Burial (Spe	1/20	/61	Loudon Pa	irk		Ba:	ltimore,	Maryla	and	
24 FUNERAL DIREC	TOR'S SIGNATURE	0	ADDIESS 7		250 RE	EC'D BY REGIS	TRAR 256 REGI	STRAR'S SIG	NATURE	
M MA	Is chow	2. Year	o MIDE	no	Ores / DATE	JAM 1 8 '	61 (thus &	FERRICA	

VR A15 (4) 1SM E/S9

TO HOSP

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24





424 CERTIFICATE OF DEATH Reg. Dist. No. (42) director, filed with PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased I ved I f institution. Residence before admission) filed **b.** COUNTY MARYLAND funerof CITY OR TOWN (If autside corporate limits, write c. LENGTH OF STAY IN 1h c. CITY OR TOWN (If guitaide corporate limits, write RURAL and give negrest fown) pe RURAL and give nearest town) should d. NAME OF HOSPITAL (If not in haspital, give street address) e. IS RESIDENCE the d. STREET ADDRESS OR INSTITUTION ON A FARM? 20 YES NO, DATE OF DEATH NAME OF Middle First Month Year Filled DECEASED (Type or print) 196 IF UNDER 1 YEAR IF LINDER 24 HRS S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED N. B. DATE OF BIRTH 9. AGE (In years last birthday) Months Days camplete WIDOWED [DIVORCED popers. 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY, 11 12. CITIZEN OF WHAT COUNTRY? deoth during most of working life, even if retired) puo carbon ofter 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME physician remove WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. INFORMAN' Address 2 attending Š 18. CAUSE OF DEATH [Enter only one couse per lingsfor (o), (b), and (c).] INTERVAL BETWEEN PART I, DEATH WAS CAUSED BY IMMEDIATE CAUSE (o **DUE TO** Conditions, if any, which (b) gned gove rise to immediate per DUE TO cause (a), stoting the underlying cause lost. PART H. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FERMINAL BYSEASE CONDITION GIVEN IN PART US) 19. WAS AUTOPSY PERFORMED? YES NO 206. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury to Part I or Part I of item 18 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Hame, form, 20f (City or town) 20c. TIME OF INJURY Month, Day. Year 20d. INJURY OCCURRED (Stote) (County) factory, street, office bldg., etc.) Hour a. m. While Not while of work of work 21. I certify that I attended the deceased fram Lithat I last saw the deceased alive an and-that death accurred at 2 M, fram the causes and an the date stated above. DIRECTOR DATE SIGNED ADDRESS (Street) Towe, state) ACTUAL SIGNATUR ö 3 should PHYSICIAN'S NAME (Type) 22b DATE THEREOF 220. BLRIAL OREMATION, 22d. LOCATION (City, tawn, ar county) 22c NAME OF CEMETERY OR CREMATORY (Stote) pode REMOVAL (Specify) he 0 23. FUNERAL DIRECTOR'S SIGNATURE 24b REGISTRAR'S SIGNATURE 24g. REC'D BY REGISTRAR VS A1S (4) Orthog S. Kraces DATE 15N 2 3 '61 1SM 9/5B

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



E. IS RESIDENCE

ON A FARMS.

YES TI NO PA

Yeor

YES X NO

22h DATE SIGNED

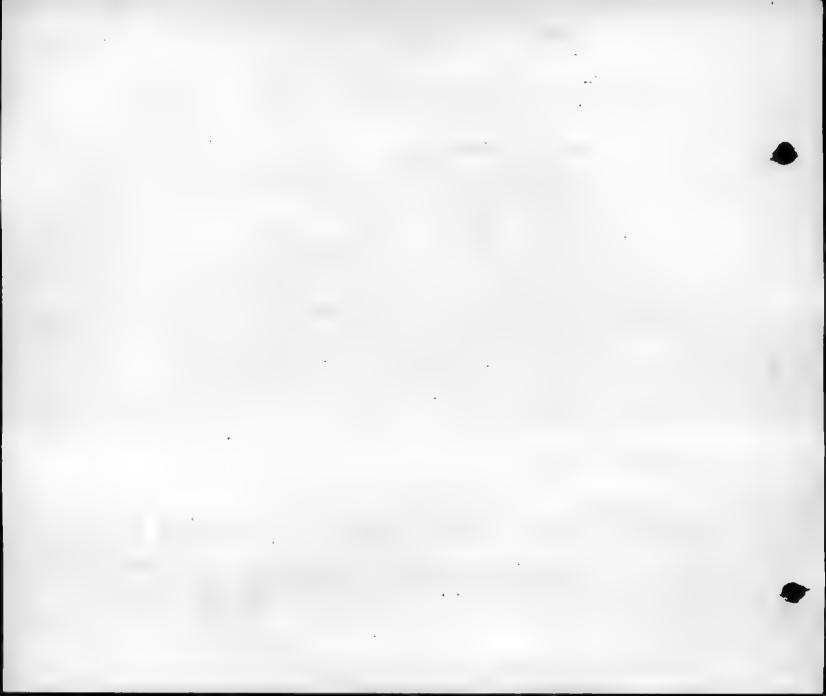
(State)

(Stote)

196 7

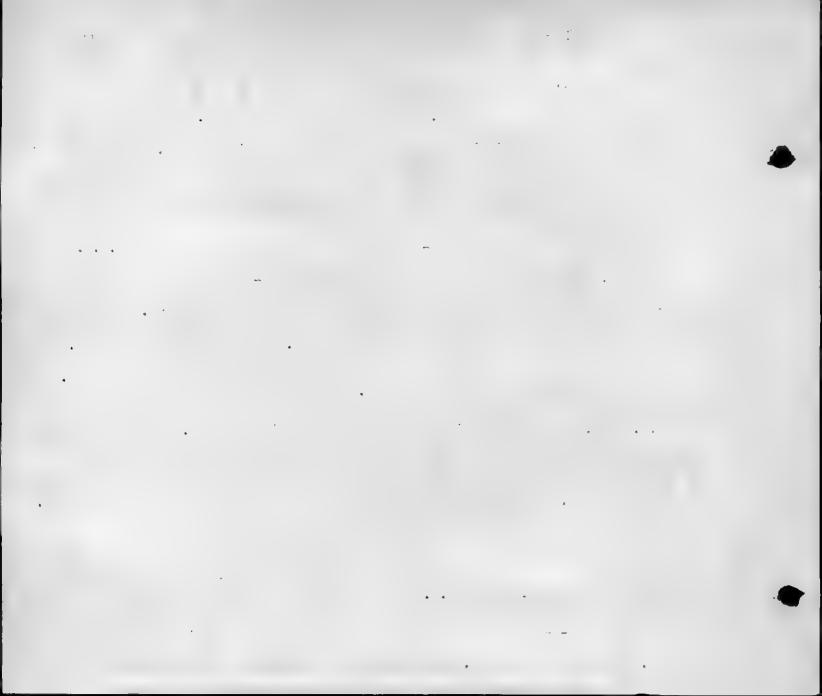
il director, filed with funeral uld be fi camplet and physicion offending gned peen DIRECTOR

VR A15 (4) 15M 9/59



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 426 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) y is necessary, I director, Page or your files, oard of Health, a. COUNTY 5. COUNTY Carroll Maryland MARYLAND Balto City b. CITY OR TOWN (if outside corporate limits, E. LENGTH OF STAY IN 15 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) I for your I Board of I wr.te RURAL and give nearest town) Sykesville 2mos. 27days Baltimore 18. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospita, give street address) d STREET ADDRESS S RESIDENCE ON A FARM? Springfield State Hospital 3016 Guilford YES NO 3 NAME OF Middle 4. DATE Month DECEASED 2 with the (Typa or print) Georgia Potter Bowlus DEATH 196] January 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 19. AGE (In years , IF UNDER 1 YEAR IF UNDER 24 HRS iould be executed within 24 hours after dea "in pencil in Item 18. Give Pages 1, 2, and 3 Office along with form PM3, Page 5 may buriel-transpormit. File pages 1 and 2 will movel, and M any event within 72 hours a last birthday) Months Whi te January WIDOWED T DIVORCED 10a. USUAL OCCUPATION (Giva kind of work I IDb. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) Housewife Maryland U.S.A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Abraham S. Potter Modessa -Jones 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT (Yas, no, or unkown) | (If yes give war or dates of service) Springfield Fospital Records. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] NIERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY. Bilateral tronchopneumonia. IMMEDIATE CAUSE (a) Days. DUE TO Conditions, fany, which Multiple infarcts in brain, probably due to "pending" gava risa to immadiata cause arteriosclerosis. DUE TO (a), stating the undarlying lease execute the certificate, writing the word "Pending should be forwarded to the Chief Medical Examiner" PUNERAL DIRECTOR: Page 3 should be used as ris designated agent, prior to burial, cremation, or n cause lest. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1181, 19. WAS AUTOPSY CERTIFICATION C.B.S. assoc. with senile brain disease with psychotic reaction. PERFORMED? YES TO NO 20a. EXTERNAL CAUSE WAS 206. DESCRIBE HOW INJURY OCCURED, (Enler nature of injury in Part 1 or Part II of item 18.) PRIMARY | or CONTRIBUTING | CAUSE OF DEATH. Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or lown) (County) (State) factory, street, office blog., atc.) Not While 60al work at work [3] Baltimore Inknown City Md. 21 I certify that I took charge of the remains described above, held an Autopsy Inspection K. Inquiry X and in my opinion death resulted from: Natural causes Accident | | Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER [ACTUAL ASSISTANT MEDICAL EXAMINER DATE SIGNED SIGNATURE DEPUTY MEDICAL EXAMINER James T. Marsh, M.D. Address (Street, city, town, or county) 22c. NAME OF CEMETERY OR CREMATORY 22a, BURIAL, CREMATION, 22b, DATE THEREOF 22d. LOCATION (City, lown, or country) REMOVAL (Spacify) 409 Burial 1-9-61 Baltimore Baltimore Harvland
24a, REC'D BY REGISTRAR 24b, REGISTRAR'S SIGNATURE 23. FUNERAL DIRECTOR VS. AISME 5M 7/59 John O. Mitchell & Sons, Inc. 1900 Eutaw Place

MARYLAND STATE DEPARTMENT OF HEALTH



Washington

18,

U.S.A.

e. IS RESIDENCE

ON A FARM?

YES NO TO

19

INTERVAL BETWEEN ONSET AND DEATH

2 weeks

Years

Years.

(County)

25h KEGISTRAR'S SIGNATURE

250 REC'D BY REGISTRAR

DATE JAN

PERFORMED?

YES 🛅 NO

22b DATE

(Stote)

(Stote)

61

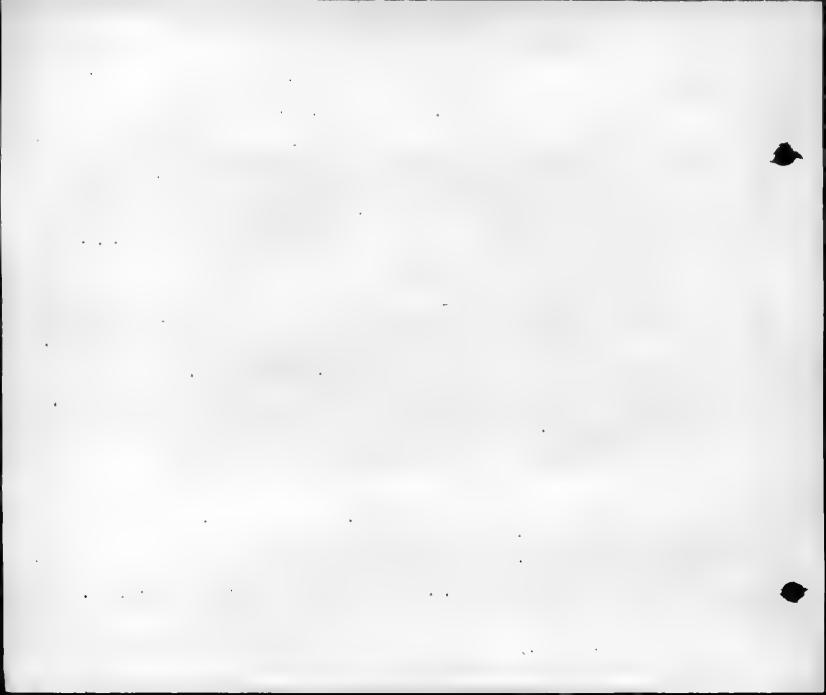
after death. Page

attending physician

PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY p. STATE b. COUNTY Carroll MARYLAND Maryl and b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 2mos. 4days Sharosburg d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS OR INSTITUTION Springfield State Hospital NAME OF Middle 4. DATE Franklin James Brashears January DEATH (Type or print) 6. COLOR OR RACE 7 MARRIED TO NEVER MARRIED B. DATE OF BIRTH 9. AGE (In yours IF UNDER 1 YEAR IF UNDER 24 HRS last birthday) Months Days Male White April DIVORCED [7] WIDOWED | 100 USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Maryland 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME Charlotte Peterman Thomas Brashears 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no. or unknown) Springfield Hospital Records 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: Congestive heart failure IMMEDIATE CAUSE (o) **DUE TO** Arteriosclerotic cardiovascular disease. gove rise to immediate **DUE TO** cause (a), stating the under-Coronary artery disease. CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY Senile psychosis. 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port 1 or Part II of item 18) 20c. TIME OF INJURY Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) foctory, street, office bldg., etc.) Hour g. m. While Not while of work of work p. m. 21 I certify that (I) (this haspital) attended the deceased from Nov. 14. 1960 to Jan. 18. ___, 19.61, that (I) (we) last 19 60, and that death accurred a 9:30 PM ram the causes and an the date stated above saw the deceased alive an Jan. 220 SIGNATURE ATTENDING PHYS STAFF PHYS X DIRECTOR [M.D 22c PHYSICIAIS 22d ADDRESS delCampo, M.D. Springfield Hospital, Sykesville, Md. Agustin 236 DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d LOCATION (City, town, or county) 23o, BUR AL CREMATION. REMOVAL

ADDRESS

24 EUNERAU DIRECTOR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS - BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

FBADBY

	424	CERTIII	CAIL	JI DEAIII			- tr	13 45 4
I. PLACE OF DEATH				UAL RESIDENCE (Wh			sidence befare o	odmiss an)
o COUNTY Ca	rroll	MARYL	AND d.	Maryla Maryla	and	. COUNTY	Freder	Lck
b. CITY OR TOWN RURAL and give	(If outside carparate limits,	write c LENGTH OF STAY II	N 1b c.	CITY OR TOWN (If o	utside carporote lin	its, write RURAL	and give neares	t town)
	nryton	313 days		Freder	ick		1 :	0.3
d. NAME OF HOSP OR INSTITUTION	ITAL (If not in haspital giv	e street address)	d.	STREET ADDRESS				S RESIDENCE
Her	nryton State	e Hospital		29 S.	Court St	reet	Y	ES NO
3 NAME OF DECEASED	First	Middle		Last	4. DATE OF	Month	Day	Year
(Type ar print)	Eugene	Augustus		Brown	DEATH C	anuary	14	1961
S SEX	6. COLOR OR RACE	7. MARRIED 🔼 NEVER MARRIEI	D B DATE	OF BIRTH	9. AG	E (In years IF UI birthdoy) Mar	NDER TYEAR IF	UNDER 24 HR
Male		VIDOWED DIVORCED		22-1900	60	yrs		
On JSUAL OCCUPAT during most of wo	ION (Give kind of work do irking life, even if retired)	ine 10b. KIND OF BUSINESS OR	INDUSTRY	BIRTHPLACE (Stote	ar foreign cauntry)	1:	2.CITIZEN OF W	_
Labore:	r	รีสีทุร์ทร์ หลาดหลังสาริ	545 N	rrederic	ok, Ma.		U. S.	A.
13. FATHER'S NAME			14 /	MOTHER'S MAIDEN N				
_	s Brown			Maryetta	4 Lembre			
(Yes, no, or unknown)	'ER IN U. S ARMED FORCI	ES? 16 SOCIAL SECURITY NO	17, INFORMA			Frede	rick-L	d.
No		214-10-5186		Eugene A	1. Brown	88	S. Cou	
		ee per line for (a), (b), and (c).] Cardiovascu		sufficier	су		ONSET	AL BETWEEN
1 4.2 %	DUE TO							
Conditions, if	any, which) (b)_	□ Cancer of t	he lun	g				
gove rise to cause (o), stating	immediate Dus TO	- "						
lying couse lost								
PART II. O	THER SIGNIFICANT COND	ITIONS CONTRIBUTING TO DEA	TH BUT NOT R	ELATED TO THE TERMI	INAL DISEASE CON	DITION GIVEN II		WAS AUTOPS' PERFORMED? ES NO [
20g. ACCIDENT V OR CONTRIBUTION (IF EITHER, NOTIF	/AS UNDERLYING ☐ 2 G ☐ CAUSE OF DEATH Y MEDICAL EXAMINER)	06. DESCRIBE HOW INJURY OC	CURRED (Ente	r nature of injury in	Part 1 or Part II of	tem 18.)		
Z 20c. TIME OF INJU	IRY Month, Day, Year	20d. INJURY OCCURRED	20e PLACE OF	INJURY (Hame, farm	, 20f (City or to	νπ)	(County)	(Stat
20c. TIME OF INJU	10	While Not while of work	factory, st	reet, office bldg., etc	-) [
		attended the deceased	Ms	rch 7. 10	60 La Jami	1ary 14	4061 that	III Juga I In
saw the dece	ased alive an Jan	• 14, 19 61, and		accurred at 7:1				tated abov
220. SIGNATURE	dyans mi	manlung	M D, P	ATENDING M	ED STA	FF rs 🗆		226 DATE SIGNE
22c PHYS CIAN'S NAME (Type)		Maculans, Supt		2d ADDRESS [enryton S		spital,	Henryt	on, Md
230. BURIAL, CREMAT	ON, 23b. DATE THEREOF	23c NAME OF CEME	TERY OR CREM	ATORY	23d LOCATION (City fown, or co	unly)	(State)
Buria I	" 1-17-61	Bartonsv	rille		Freder	cick Co		
24 FUNERAL DIRECTO		ADDRESS		*	D BY REGISTRAR	256 REGISTRAI		
C.E. Hick	s lll F	rederick, Na	rylan	d DATE	JAN 1 8 '61		hur S. Fliai	ulil.

on by the funeral director, and 2 should be filed with ofter death. Page TO HOST ALOR ATTENDING PHYSICIAN: The law requires that the deoth certificate be executed within 24 may be anned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled page 3 should be detached far use as the burial-transit permit. Then please remave carbon papers Pages 1 the Stote Board at Health priar to burial, cremation, or remayal, and in any event, within 72 hours after death.

9

VR A15 (4) 15M 9/59



e. IS RESIDENCE ON A FARM?

Haves

INTERVAL BETWEEN ONSET AND DEATH

YES TO NO TO

22b DATE

(Stote)

 $M_{\mathbf{Z}}$

(Stote)

Davs

(County)

25b REGISTRAR'S SIGNATURE

25a. REC'D BY REGISTRAR

YES NO F

1961

PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY o. STATE Maryland b. COUNTY Baltimore City Carroll MARYLAND c. LENGTH OF STAY # 15 CITY OR TOWN (If outside corporate limits, write c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural ond give negres town)
Sykesville 12vrs.7mths Baltimore City d NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS OR INSTITUTION 3907 Pinewood Ave. (Overlea Springfield State Hospital. DATE OF DEATH NAME OF DECEASED Myrtle Mabel Brown (Type or print) 5 SEX 9. AGE fin years IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH lost birthday) Months Whi.te Female 11-30-189b WIDOWED | DIVORCED [yrs 10a USUAL OCCUPATION (Give kind of work dane) 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or fareign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) U.S.A. Housework Maryland HOUSEWORK 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME Albert. Lee Brown Anna Mary Steigewald 17. INFORMANT 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address Hospital records Un known NOUE 1B CAUSE OF DEATH [Enter anily one couse per line for (o), (b) and (c).] DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if only, which (b) gove rise to immediate **DUE TO** cause (a), stating the underlying cause lost. Schizophrenic Simple type/ 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 11 of Item 18.) 20c. TIME OF INJURY Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f (City or town) foctory, street, office bldg., etc.) Hour o. m Not while at work at work 21. I certify that (I) (this haspital) attended the deceased fram 11-15-60 1961 and that death accurred at 9.3M, from the causes and on the date stated above saw the deceased alive an ATTENDING MED DIRECTOR STAFF PHYS IXI 72c. PHYSICIAN'S NAME (Type) 22d. ADDRESS Springfield State Hospital Sykesville, Md. Campo MaD Agustin del 23g. BURIAL, CREMATION, 23b. 23c NAME OF CEMETERY OR CREMATORY 23d LOCAT ON (City, town, or county) REMOVAL (Specify)

15M 9/59



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 431

0.0420

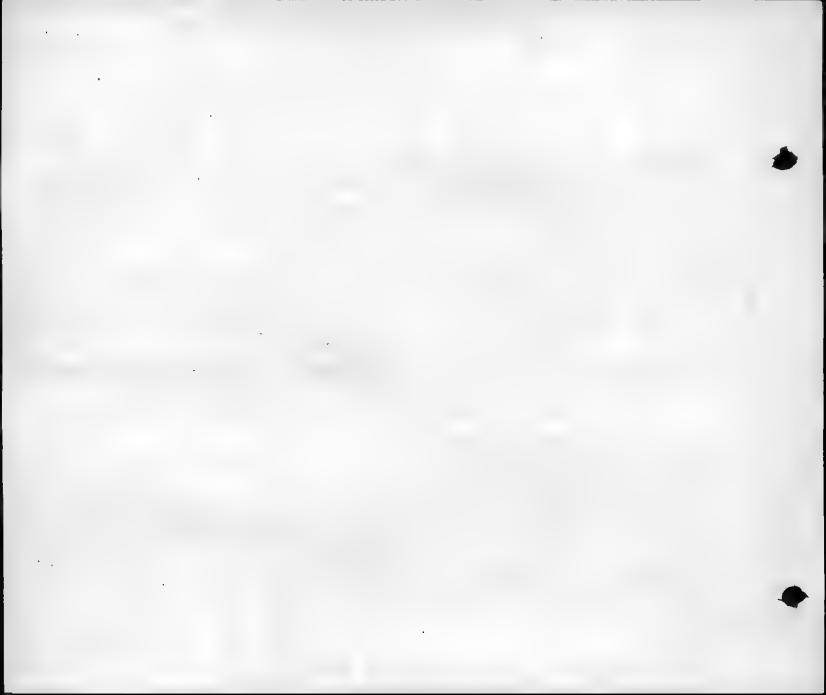
PLACE OF DEATH o. COUNTY MARYLAND	2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) b. COUNTY b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write c LENGTH OF STAY IN 16 RURAL and g ve nearest toward	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lown)
d. NAME OF HOSPITAL (if not in hospitol, give street address) OR INSTITUTION	d. STREET ADDRESS e IS RESIDENCE ON A FARM
- gwebster IT.	yes No
3 NAME OF DECEASED (Type or print) NELLIE LEE	BROWN 1. DATE Month Day Year DEATH Jun 24 196
5. SEX 6. COLOR OR RACE 7 MARRIED NEVER MARRIED DIVORCED DIVORCED	B. DATE OF BIRTH Sent 17 1806 9 Age (n years IF UNDER 1 YEAR IF UNDER 24 Manths Days Hours M
106 USJAL OCCUPATION (Give kind of work done 106 KIND OF BUSINESS OR INDU during most of working life, even if setired)	STRY 11 BIRTHPLACE (Stole or foreign country) 12 CITIZEN OF WHAT COUNT
18 PATHER'S NAME	wormmen ma. U.J. 4.
All the state of t	14. MOTHER'S MAIDEN NAME
15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SPOURITY NO 17 J	NFORMANT Address
Yes, no, or unknown) (If yes, give wor or dates of service)	10 mon B. Kleyou gwebster It
18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]	INTERVAL BETWEE
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (o)	Occusion Thou
TAO DUE TO	the day of the Car
Conditions, if ony, which (b)	factores 11/1
couse (a), stating the <u>under-</u> lying couse last. DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT	T NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART T(0) 19 WAS AUTO PERFORMED
3 Caremonin of ston	YES NO
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	ED. (Enter nature of injury in Port I or Port II of stem 18)
9	ACE OF INJURY (Home, form, 20f (City or town) (County) (Strony, street, office bldg., etc.)
Hour o.m. 19 While Not while to at work at work	City, sires, vince stog., atc.,
21. I certify that (I) (this haspital) attended the deceased fram	Copr 21 1955. to Jan 24 , 1961, that (1) (we)
saw the deceased alive on Jan 24 1961, and that a	death accurred of 57.M, from the causes and an the date stated abo
220. GRATURE Charke	M.D ATTENDING MED STAFF DIRECTOR DIRECTOR PHYS D
22c PHYSION'S Julius Chepka	85 When Wortenmh Mes
230 BURIAL, CREMATION, 236 DATE THEREOF 23c NAME OF CEMETERY C	OR CREMATORY 23d LOCATION (City, lown, or county) (State)
Dureal 127/61 MAN Man	alle Comling Westmenter, mit
24 PINERAL D RECTOR'S SIGNATURE ADDRESS	256 REGISTRAR S SIGNATURE
T- V / / MARAO . YJ . / SINON BARRANI!	DATEAN 2 7 '61 Cours & Toward

TO HOSS.

OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 years after death. Page 4 may be called by the haspital ar attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled to by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remays-carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, ar remayor, and in any event, within 12 haurs after death VR A15 (4) 15M 9/59

1

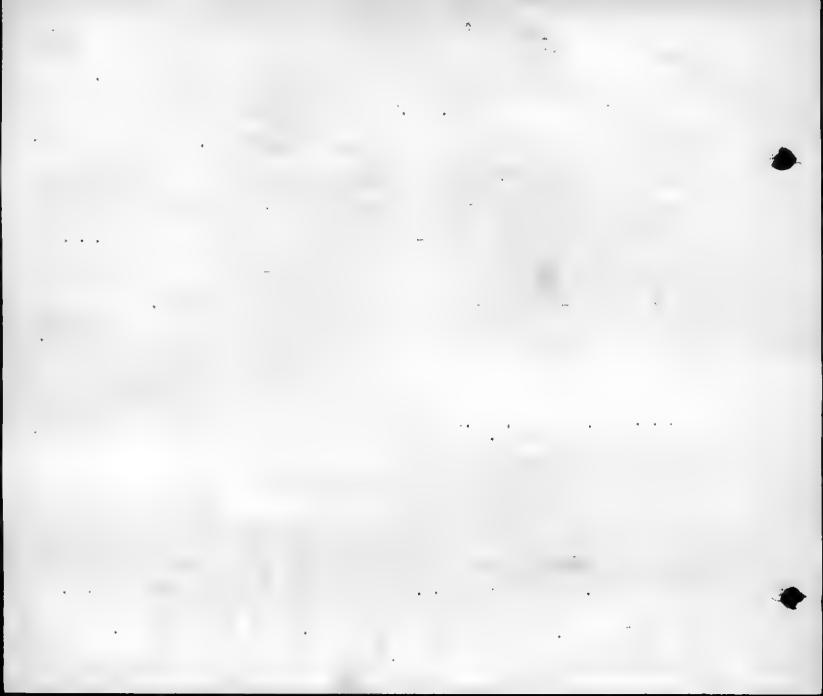


9		tar,	with	
Pag		dire	eq	,
ath.		p.a	be fi	
ar de		foli	믈	/
affe		the	shc s	
SUC		9	Pul	
24		į	-	-
hin		Ē	ages	Jeot 1
ž		efei	<u>.</u>	jer
ured		ldmo	pers	20
exec		ğ	P. P.	À
0		10 01	arba	n 72
cate		rsicio	ve c	withi
ertifi		phy	emo	ent
th c		ding	ose (y ev
dec		atten	o lo	no n
t the		the	Then	Pu
tha		þ	:=	۵, ۵
vires		gned	Der m	YDE:
red	ian.	n Sig	Tsit	OF TE
30	ysic	bee	fra	on,
The T	g p	has	urial	mafi
Ä	ndin	cate	he b	, cre
SICI	otte	ertifi	03 1	urial
PHY	a a	Sis o	USe	to b
DN N	spite	ler #	d for	rior
9	e ha	: Af	ch≣c	丰
ATTE	y th	10	deto	Heo
OR /	a pa	IREC	90	daf
ř	ā	400	ould	Boar
TO HOSS. LOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4	may be ained by the haspital ar attending physician.	TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fille who by the funeral director,	page 3 should be detachmd for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 shauld be filed with	the State Board of Health prior to burial, cremation, ar remayal, and in any event, within 72 hours after death
유	nox	3	ago	he S
10		0	a	Ξ

VR A1S (4) 1SM 9/S9

LOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

	2013					00100
1. PLACE OF DEATH a. COUNTY Ca	erroll	MARYLAND	2. USUAL RESIDENCE (Who a. STATE Mary		CONTRACTOR OF THE PARTY OF THE	ence before admission).
b. CITY OR TOWN (RURAL and give n Sykesvil		Lyrs. 6mos. 22d	c. CITY OR TOWN (If or	unide corporate limi	its, write RURAL and	d give nearest town)
OR INSTITUTION	ITAL (If not in hospital, give streeted State Hosp		d. STREET ADDRESS 915 Eas	tern Ave.		e IS RESIDENCE ON A FARM? YES NO 1
3. NAME OF DECEASED (Type or print)	Virgini	a Middle Lave	zza Bruni	4. DATE OF DEATH	Month January	Doy Year 17, 1963
S SEX	6 COLOR OR RACE 7. MA	ARRIED NEVER MARRIED	8 DATE OF BIRTH	- lost l		ER TYEAR IF UNDER 24 H
Female	White wido	WED 🛣 DIVORCED 🔲	November 15	, 1879	81 yrs. Manths	Days Haurs Min
dur ng most of wor Seamstres	rking life, even if retired)	b. KIND OF BUSINESS OR INDU	STRY 11. BIRTHPLACE (Stole Maryland		12. CI	U.S.A.
13. FATHER'S NAME			14 MOTHER'S MAIDEN N			
Joseph La	avezza		Theresa	-		
15. WAS DECEASED EVI	[If yes, give war or dates of service]		pringfield Ho	spital Re	Address cords.	
Canditions, if a gave rise to cause (a), stating lying cause last.	DUE TO Only, which immediate the under- (c) (c)	Silateral bronch	*	hay disease cont	DEPON GIVEN IN P	ONSEY AND DEATH
200. ACCIDENT W OR CONTRIBUTING	chotic reaction	1150, WI OH COTEL ESCRIBE HOW INJURY OCCURRE				YES NO
20c. TIME OF INJU	Whi	£_	ACE OF INJURY (Home, form ctory, street, office bldg., etc		n)	(County) (Sta
saw the decea	at (I) (this haspital) atte used alive an January	nded the deceased fram	June 25, 19			
22c PHYSICIANS	. Raymor	nd Glader	ATTENDING ME PHYS DI	ED STAF	s E	1/17/61
NAME (Type)	J. Raymond Gl	ladue, M.D.	Springfie	ld Hospit	al,Sykesv	ville,Md.
230. BURIAL, CREMATIC REMOVAL (Specify Burial	ON, 23b. DATE THEREOF	1 Holy Radee		The State of the Control of the Cont	ity, town, or county	(Stote)
24 JUNERAL DIRECTO	R'S SIGNATURE	ADDRESS 322 S.H			25b REGISTRAR'S	



DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

0043:

	433	CERTITION	TIE OI DEATH		
1, PLACE OF DEATH			2. USUAL RESIDENCE (Where	deceased lived. If institution	n: Residence before admission)
o. COUNTY	1017	MARYLAND	o. STATE Marvlan	d b. COUNTY	Carroll
	outside corporate limits,	write c. LENGTH OF STAY IN 16		ide corporate limits, write RU	4041041
RURAL and give near	est town)		Mt. Airv		
Sykesvill	L (If not in hospital, give	street original	d. STREET ADDRESS		e. IS RESIDEN
OR INSTITUTION					ON_A FAR
Pullen Nu	arsing Hom	1e	Park Av	e.	YES NO
3. NAME OF DECEASED	First	Middle	Last 4	DATE Month	h Day Yeor
(Type or print) SAF	<u>RAH</u> SAU	JBLE BUSHEY		DEATH January	9, 196
5 SEX	6. COLOR OR RACE 7.	MARRIED NEVER MARRIED	B. DATE OF BIRTH 1873		Months Days Hours N
Female	White w	IDOWED DIVORCED	September 13	lost birthdoy) 87 yrs.	Months Days Hours N
10a. USUAL OCCUPATION	(Give kind of work don	e 106. KIND OF BUSINESS OR IND		fareign country)	12 CITIZEN OF WHAT COUN
during most of working Housewife		Domestic	Maryland		U. S. A.
3 FATHER'S NAME	,		14. MOTHER'S MAIDEN NAM		
Cooman I	W. Mullini	32	Mongo	ret Mount	
			Marga Marga	Addre	Acc.
	yes, give war or dates of service	el el			
			Mr. Harry L.	pasney, be	ame as No.
		per line for (0), (b), and (c).]	. 0	,	INTERVAL SETWE
	I WAS CAUSED BY: MMEDIATE CAUSE (o)	Carrier f	article, lu	muplique.	An
24	DUE TO	2 4/)		11.	1959
Conditions, if ony	which) (b)_	luxueles	un, Certe	riordun	
gove rise to im-	mediate Dus TO			1 1	70
couse (o), stoting the	e under-	Ortings !	when been	A duces	1961
_	R SIGNIFICANT CONDIT	TONS CONTRIBUTING TO DEATH BU	JT NOT RELATED TO THE TERMINA	L DISEASE CONDITION GIVE	N IN PART I(o) 19 WAS AUTO
PART II. OTHER					PERFORME
D COURTE WAS	th incommiss Ed. 100	L DESCRIPE HOW INDIAN OCCUPA	ICD (C. A	t Lee Best II of Hem 19 v	YES NO
20a. ACCIDENT WAS OR CONTRIBUTING D	CAUSE OF DEATH	6. DESCRIBE HOW INJURY OCCUR	EU (Enter noture of injury in For	r Or Par) II or Hent to.)	
	· · · · · · · · · · · · · · · · · · ·				
20c TIME OF INJURY Hour o.m., p. m.	Month, Doy, Year		PLACE OF INJURY (Home, form, cotory, street, office bldg., etc.)	20f (City or town)	(County) (S
p. m.	19	While Not while of work of work	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
21 I contifu that	II) Ithis hasnitalled	ttended the deceased fram	195510	10 9 Jan	196/, that (I) (we)
		1. /4/	41 R	6	
saw the deceased	a alive an	and that	death accurred at 1.30 M	, from the zauses and	an the date stated ab
220 3/GIVATO	Enra OV	S XIII	ATTENDING MED	STAFF	4 m Q SIG
On Directory in	- WWW	c prace		TOR PHYS	10 Jan 60
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS		
I	Howard E.	Hall M. D.	Sykesvil	le, Marylar	<u>ad</u>
230 BURIAL, CREMATION,	23b DATE THEREOF	23c NAME OF CEMETERY	OR CREMATORY 23	d LOCATION (City, fomin, o	r county) (Stote)
Burial	Jan. 12.	1961 Westminst	er Cemeterv	Westminster	r. Carroll.
24. FUNERAL DIRECTOR'S		ADDRESS	كناك والمستقل المستحد المستحد المستحد		TRAR'S SIGNATURE

Maryland

DATE 1 2 '61

Olleg & Krus

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24, moy be realised by the hospital ar attending physicion.

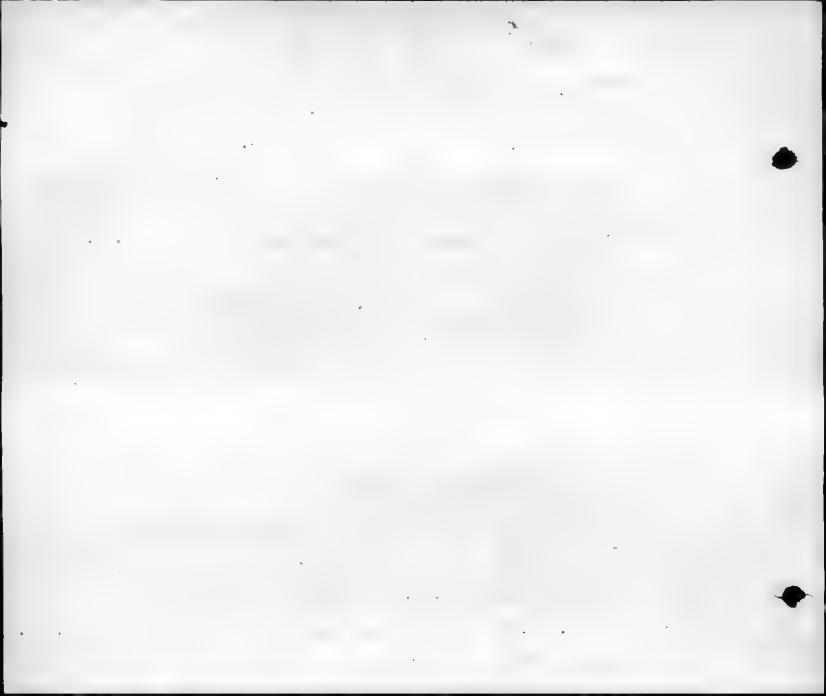
TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physicion and campletely fille, page 3 shauld be detached for use as the burial-transit permit. Then please remaye carbon popers. Pages 1 the State Board of Health prior to burial, cremation, or remayol, and in any event, within 72 hours after death. TO HOS VR A15 (4) 15M 9/59

C. M. Waltz,

Winfield,

urs after death. Page 4

the otherding physicion and campletely filled to by the funeral director, Then please remove carbon popers. Pages 1 and 2 should be filed with



TO HOSP OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 softer death. Page 4 may be correctly the hospital ar attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled. By the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remaine carban papers. Pages 1 and 2 shauld be filled with the State Board of Health prior to burial, cremation, ar remaind, and in any event, within 72 hours after death. VR A15 (4) 15M 9/59

	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
	434 CERTIFICATE OF DEATH
2	1. PLACE OF DEATH a. COUNTY MARYLAND 2. USDAL RESIDENCE (Where deceased lived if institution Residence before admission) b. COUNTY b. COUNTY
	b. CITY OR TOWN (If butside corporate limits, write RURAL and give nearest town) RURAL and Juve nearest town) C. LENGTH OF STAY IN 1b C. GITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
	d. NAME OF HOSPITAL (IF not in hospital, give street address) OR NSLITUTION ON A FARM? YES NO.
	3. NAME OF DECEASED (Type or print) Output Middle Coster DEATH January 8, 196/
	5 SEX 6. COUR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH WIDOWED DIVORCED DIVO
	100 USJAL OCCUPATION (Give Ind of work done during most of waking life, even if relired) 105. KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (State or fareign country) 112 CITIZEN OF WHAT COUNTRY?
	13. FATHER'S NAME ROPER'S MAIDEN NAME L'AMONTER'S MAIDEN NAME L'AMONTER'S MAIDEN NAME
	15. WAS DECEASED EVER IN J. S. ARMED FORCEST 16 SOCIAL SECURITY NO REPORMENT (If yes, give wor or dates of service) The Social Security NO Security
	18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).] PART I, DEATH WAS CAUSED BY: MMEDIATE CAUSE (a)
	Conditions, if ony, which) (b)
	gove rise to immediate couse (a), stating the under. Lying cause lost DUE TO CBS. Love. A. L. Leveller Extension
	PANT II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED YES NO
	20a ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
	20c TIME OF INJURY Month, Day, Year Hour a.m. p. m. 19 of wark of ot wark of
	21 I certify that (I) (this haspital) attended the deceased fram. D = 1954, ta 1954, ta 1954, that (I) (we) last saw the deceased alive an 1954, and that death accurred at 1954, the fram the causes and on the date stated above
	220 VGNATURE ATTENDING MD DIRECTOR STAFF S GNED
	PHYSICIAN'S NAME (Typeron Nizankowsky Springf State to part
	230 BURIAL, CREMATION, 236 DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City, town, or county) (Stote)
	24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS ADDRESS 250 REC'D BY REGISTRAR'S SIGNATURE DATE JAN 1 0 '61 CITCHIA & THURA



00433

1		200						00-	
)		PLACE OF DEATH D. COUNTY MARY	TAND	2. USUAL RESIDENCE (Who a. STATE	ere deceased is	ved If institution b. COUNTY	n- Res dence be	fore admis	sion)
		LXILIC	CAND	127 11.7	len.		Part I W	eti	
	Ŀ	CITY OR TOWN (If autside corporate limits, write RURAL and give nearest tawn)	IN 1b	CITY OR TOWN (IF	utside carporati	e limits, write RL	RAL and give	nearest taw	n)
1.	1.	14ct reti	1/20	14: - Et 1	1707	2 2 3 4 5 2	4. 1		
*		d. NAME OF HOSP TAL (If not in hospital, give street address)	-	d STREET ADDRESS				e IS RE	SIDENCE
		OR INSTITUTION		12 .1. 1.	11.				A FARM?
		the total a 11 100 Take		VI a FIRE	47:10			1127] 140 []
	1	NAME OF, First Middle DECEASED (Type or print)	-45	HING	4. DATE OF DEATH	A Mont	h /	Day	Yeor 196 /
	5. 5	EX [6. COLOR OR RACE 7. MARRIED] NEVER MARRIE	ED 🗍	8 DATE OF BIRTH	9		IF UNDER 1 YE	AR IF UND	ER 24 HRS.
	7.	"- LIL MY TO WIDOWED - DIVORCEE		Sust-19 18	73 1	Post birthdoy)	Manths Day	s Hours	Min,
	10a		R INDU	STRY 11. BIRTHPLACE (Stole	ar fareign caun	lry)	12. CITIZEN	OF WHAT	COUNTRY?
		during most of working life, even if retired)		11	1. 7	1 1	11	-	. ,
	1	most wife		Ch little	601/2	-21	161	U ' C	1 .
	13.	FATHER'S NAME		14. MOTHER'S MAIDEN N	IAME		/		
		Maker & word like	_	172 12 17	nand	ale.	Je Pa		
1	15	WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO	177 IN	NFORMANT	maga:	Addr	ess	Carried .	
	(Yal	(no. or unknown) (If yes, give wor or dates of service)	4	I FALL	1	9. 1	7	820	^9 .
	1_,		1991	A LIA TALLE	- Taga	with.	2-26		in the
/		18. CAUSE OF DEATH [Enter only one cause per lige-(or (o), (b), and (c).]	1	15	17	-	111	NTERVAL 8	ETWEEN
		PART 1 DEATH WAS CAUSED BY:		and Fillia	1//		0	NSET ANI	DEATH
		IMMEDIATE CAUSE (a)	adri	29 1 KROY	while	and _	/	-CU HI	rull
		DUE TO	(P)	/ // .	,	0			
		Conditions, if any, which } (h)	سک	elevore	- Tu	and		01.	10.46
		gove rise to immediate DUE TO			1	- 1		11	and the second
		lying cause lost.	11.	+ + Hund	. Mal	Meson	enter	1.6	4
-15.	7	- Of H		4 Mari	are	- 1			A.UT OBOV
1	Ō	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEA	AH BUI	NOT KELATEURO THE TERM	INAL DISEASE C	ONUJUION GIV	EN IN PAKE I(O	PERF	ORMED?
J	CAI			V				YES [] NO []
	CERTIFICATION	200 ACCIDENT WAS UNDERLYING ☐ 20b. DESCRIBE HOW INJURY OF OR CONTRIBUTING ☐ CAUSE OF DEATH	CCURRE	D. (Enter nature of injury in	Part I or Port II	of item 18.)			
		(IF EITHER, NOTIFY MEDICAL EXAMINER)	7						
	MEDICAL	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED		ACE OF INJURY (Hame, form ctory, street, affice bldg., etc		town)	(Coun	ly)	(Stote)
	AED	Hour o.m. While Nat while p.m. 19 at wark □ at work □	10	citif, meet, office bidg., etc	"	7			
	*		-	Ma.	5-E- 11	<i>C</i> 1	1.6		
		21. I certify that (I) (this haspital) attended the deceased	fram.	19	19	us.	19_621,	that (I)	(we) last
		saw the deceased alive an elle 19 1960, and	that o	leath accurred at //s	M, from th	e causes an	d on the do	ite state	d abave.
		220 SIGNATURE					1	2	7b DATE
		Willem Feller	-	M D PHYS DE DE	ED RECTOR	STAFF PHYS	- X/	2.2	SIGNED
		72c PHYSICIAN'S		22d. APORESS	KECTOR 191	11113	11	7	1/4/
		NAME (Type)		1110		1 7	(-//)	red!	
				-uca	ruce	ush	ed 1	ry_	
	230	BURIAL, CREMATION, 236 DATE THEREOF 23c NAME OF CEME	ETERY C	R'CREMATORY	23d LOCATIO	N (City, lown, o	r county)	(Ste	ole)
	-	REMOVAL (Specify)	ina +	.7 7	1	in the same	2026	2-7	
	2.	FUNEDAL DIRECTOR S SIGNATURE	FF. FF	LIEC CEPTEL	29 LL Z	Weight.	TO A DIE CLOSE	NUDE	18
	24	FUNERAL DIRECTOR'S SIGNATURE ADDRESS	-	250 REC	DIST REGISTRA	R 2Sb. REGIS	TRAR'S SHONA	TURE COLLECT	
	,	1º2 meren 1 vet service	luz.	DATE S					
	-	The state of the s							

TO HOSP. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24. April after death. Page 4 may be prined by the haspital an attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complemity filled. To the funeral director, page 3 shauld be detached for use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2 shauld be filed with the State Board of Health prior to burial, cremation, ar remaval, and in any event within 72 haurs after death.

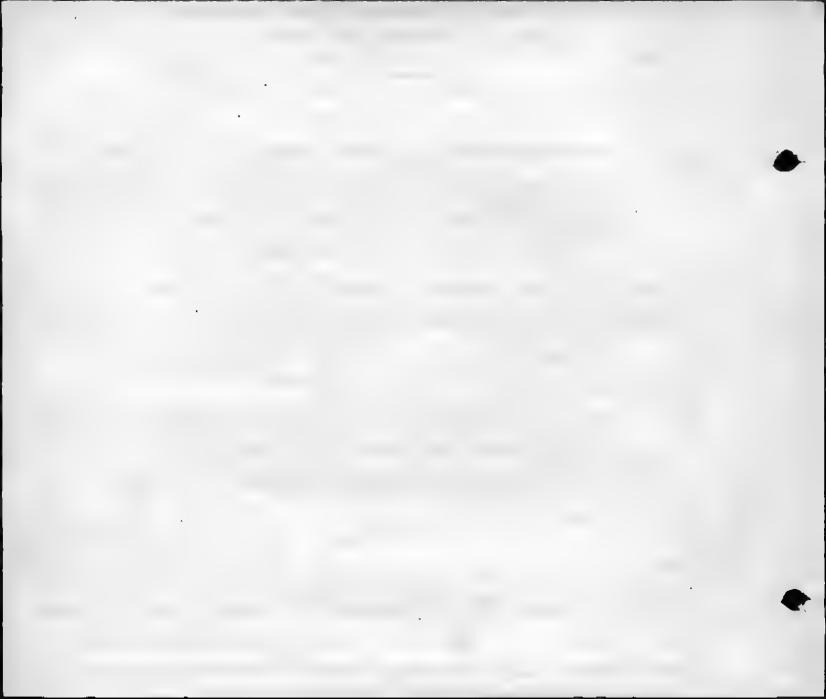
VR A15 (4) 15M 9/59



AND STATE DEPARTMENT OF HEALTH AND RECORDS. **BALTIMORE 1. MARYLAND** FOR STATE 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admiss on) uneral director. Page ained for your files. State Board of Hearth, a. COUNTY b. COUNTY CARROLL MARYLAND b. CITY OR TOWN (if outside corporate I mits, E LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate I m Is, write RURAL and give nearest town) write RURAL and a ve nearest lown) NEW WINDSUR | 1HOUR d. NAME OF HOSPITAL OR INSTITUTION (1 not in hospital, give street address) NEW d. STREET ADDRESS IS RESIDENCE ON A FARM? YES TO NO 12 NAME OF Middle 4. DATE Month Day Year Last DECEASED [Type or print] DEATH 19 6 / with 6. COLOR OR RACE 7. MARRIED NEVER MARRIED | B. DATE OF BIRTH 5. SEX AGE (In years) IF UNDER 1 YEAR) IF UNDER 24 HRS. may rage 5 m 1 and 2 w last birthday) Days Months WIDOWED [DIVORCED 10a. USUAL OCCUPATION [Give kind of work 10b. KIND OF BUSINESS OF INDUSTRY 12. CITIZEN OF WHAT COUNTRY? form PM3. Page done during most of working life, even if relized) in pencil in Item 18, Give Pages 1, 14. MOTHER'S MAIDEN NAME TRUCK FATHER'S NAME File pages IY MEDICAL EXAMINER: This certificate should be executed within 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. | 17. INFORMANT permit. I (Yas, no, or unkown) ! (If yas giva war or datas of service) Office along with burial-transit permi 18. CAUSE OF DEATH [Enter only one cause par line for (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I, DEATH WAS CAUSED BY: Pue IMMEDIATE CAUSE (a) DUE TO removal, gave rise to immediate cause "pending" the word "pending" Medical Examiner's 40 DUE TO (a), stating the undarlying Se pesn cause lest. cremation, PART I., OTHER SIGNIF. CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 19, WAS AUTOPSY CERTIMICATION PERFORMED? Medical Ex shou be t NO, 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED, (Enter nature of injury in Part I or Part II of item 18.) PRIMARY | or CONTRIBUTING | CAUSE OF DEATH. execute the certificate, writing Chief 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 1 20e. PLACE OF INJURY (Home, farm, 20f. (City or lown) (County) (Stata) factory, streat, office bldg., atc.) While Not While at work al work forwarded to the L DIREETON P. prior Inspection . Inquiry X 21. I certify that I took charge of the remains described above, held an Autopsy | |. and in my opinion Accident Suicide Homicide Undetermined manner death resulted from. Natural causes CHIEF MEDICAL EXAMINER designated ACTUAL ASSISTANT MEDICAL EXAM NER DATE SIGNED should be for FUNERAL SIGNATUR DEPUTY MEDICAL EXAMINER Address (Street, city, town, or county) 8858 CEMETERY OR CREMATORY 22d. LOCATION (City, lown, or country) (Stata) DE REMOVAL (Spacify) OH 0.45 24a. REC'D BY REGISTRAR | 24b. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR VS. A15ME Caller S. Thous 5M 7/59



VS A1S (4) 15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

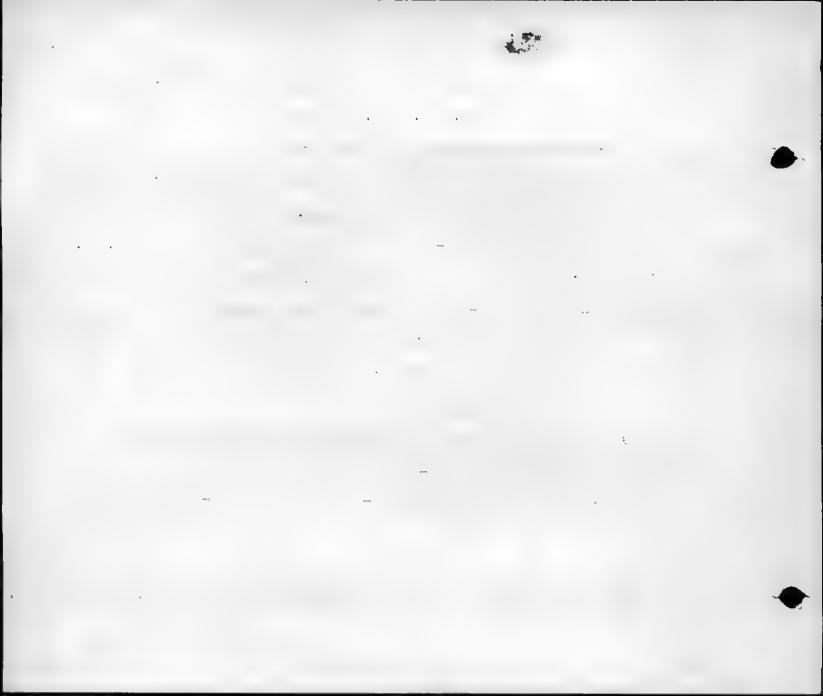
C0436

			300		•	PEKIII	CAI	E OF D	MIN							
1	1. [PLACE OF DEATH				MARY		2 USUAL RESID		iere decease		COUNTY			e admiss	or)
1	-1	Carroll CITY OR TOWN RURAL ond give	(IF outside corporate lim	nits, write	c. LENGT	H OF STAY	IN 16	c CITY OR T		outside corpo	orote limit		hing		rest town)
and the		Sykesvill	PTAL III not in hospital.	give stre		5mos.1	4das	R. 1 d. street a		ville			4	_	e IS RES	DENCE FARM?
2			1d State H	ospi	tal				_				X -	-	YES 🙀	
		NAME OF DECEASED	F	irst		Middle		Lasi		4. DATE OF		Mont	h	Do	, `	fear
	_	(Type or print)	John			_Nolar		Down		DEATH	U	anuar		23		961
	5. 5	EX	6. COLOR OR RACE	7 MA	ARRIED 📆 NE	VER MARRIE	8 🔲 d	DATE OF BIRTH	4		9. AGE	(In years irthdoy)	Months	Doys	Hours	R 24 HRS Min
		Male	White		WED	DIVORCE		3-17-8			76	yrs		0075	110013	
	10a	USUAL OCCUPAT	ON (Give kind of work irking life, even if retired	done 10	ъ. KIND OF	BUSINESS O	R INDUST	RY 11. BIRTHPL	ACE (Stote	or foreign	country)		12 CIT	IZEN OF	WHATC	OUNTRY?
		Farmer				_		Vi	rginia	a				U.S.	A.	
	13.	FATHER'S NAME						14 MOTHER'S	MAIDEN N	NAME						
		William	Downs					Lin	nnie l	Dove						
	15	WAS DECEASED EV	ER IN U. S ARMED FO	RCES?	16. SOCIAL SE	CURITY NO	17, INF	ORMANT				Addr	955			
	,		fit yes, give wor or coms or	services	-		Sm	ringfie]	A Sta	ate Ho	ospit.	a 1				
		18. CAUSE OF DE	ATH [Enter only one of	ouse per	line for (a),	(b), and (c).								INTE	RVAL BE	TWEEN
			ATH WAS CAUSED BY:					022461177.01	o to						ET AND	
		110	IMMEDIATE CAUSE (DITAGE	LWT DI	Onen	opneumo:	114						_uay	<u> </u>
		Conditions, if			A A 2	7		Ti	14							
		gove rise to	immediate		Arteri	osclei	OTIC	Heart I	<u>Jisea</u>	se				<u>_</u>	rears	1
		couse (o), stating		0					april .	•						
	z		THER SIGNIFICANT COI	(c)	E CONTRIBUTI	IINC TO DE	A THE BLET A	OT DELATED TO	THE TERM	INIAN DISSA	SE COND	TION CIVI	Chi (h) DAE	OT 14-1 19	D VACA C	VIITOBSV
	110														PERFO	RMED?
	FICA		sociated wi										ctio	n_	YES	NO 🗍
	CERTIFICATION	OR CONTRIBUTION	/AS UNDERLYING [] G [] CAUSE OF DEATH Y MEDICAL EXAMINER)	206. D	ESCRIBE HOY	A INTRKL O	CCURRED.	(Enter noture of	r injury in	POST I OF PO	or II or IIe	m Ib-j				
-	MEDICAL		IRY Month, Doy, Y		I. INJURY OC			E OF INJURY (I			ly or town	>	g ₀	County)		(Stote)
	WED	Hour a.m.	10	Wh of v	rle Not vork at w	white ork	TOCIO	my, street, office	biag , elc		-					1
	_		at (I) (this haspite	-1144-			£	Ø_10_	.10	50	1-23		106	7 4	-4 /11 /	we) last
		,	* * * *	,				ath accurred	-10 ²	27a.		<u>/</u>				
		220 SIGNATURE	sed alive an 1	1	1 6	Str and	that de	ath accurred	1 of±_	M, fram	the ca	uses and	d an th	e date		DATE .
		ame	stin d	Zel	Ens	nko	, M	D. ATTENDING	G □ M	ED.	STAFF	- -	1_23	3_61	241	SIGNED
	1	22c PHYSIC AN'S NAME (Type)						22d. ADDRE								
	P-		stin del C	ampo)	V		Sprin	gfiel	d Sta	te Ho	spita	al, S	ykes	vil	Le, Mo
	23a		ON, 236, DATE THERE			ME OF CEMI	ETERY OR	CREMATORY	<u> </u>		-	ty, town, o				
	6	REMOVAL (Specific	1/27/6	1.1		Um				XX	/	ung	,,		Stot	-
	24	FUNERAL DIRECTO	R'S SIGNATURE	,	ADD	RESS		, ,		D BY REGIS	TRAR (2Sb PEGIS				
	9	n.1k.5	Thian VS	m		tiel	und	md	DATEJAI	N 2 7 '6	51	Cirl	hur S.	Trans	ß.	
	100			_	1			7								

TO HOSP OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 they death. Page 4 may be sined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 shauld be detached for use as the burial-transit permit. Then please remove car an appears. Pages 1 and 2 should be filled with the State Board of Health priar to burial, cremation, at removal, and in any event, within 72 hours ofter death.

VR A15 (4) 15M 9/59

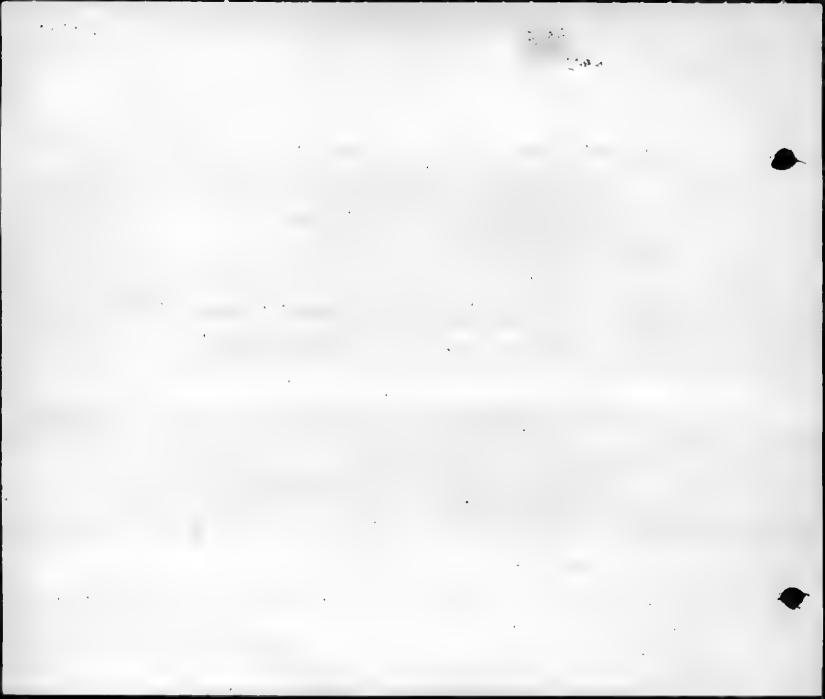


VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 439

CP437

	1. PLACE OF DEATH o. COUNTY ULTRO	2 USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) o. STATE (Maryland B. COUNTY)
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. CITY OR TOWN (If outside carporote limits, write RURAL and give nearest town)
	d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	o. IS RESIDENCE ON A FARM? 120 S. May S. YES NO.
ŧ	3. NAME OF First Middle	
	(Type or print) Levaye Nicholus	Engly- DEATH January 16 1961
	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED WIDOWED DIVORCED DIVORCED	8. DATE OF BIRTH ASE (In years MONDER 1 YEAR IF UNDER 24 HRS Months Doys Hours Min
ł	10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUS	Server 100 ch
	during most of working life, even if retired) Assurable Consultation	mary Parel 265 A.
Ì	13. FATHER'S NAME	14. MOTHER'S MANDEN NAME
ł	15. WAS DECEASED BY IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. IN	FORMANI Address
	(Yar, no, or unknown) (Ill yes, give wor or dates of service)	ne Elm Erl. manskeller Man Coul
Ī	1B. CAUSE OF DEATH [Enter only one couse per line for (a) (b) lond (c).]	INTERVAL BETWEEN ONSET AND DEATH
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)	negocarditis.
	H-3 a DUE TO	8 1 1 2
	Canditions, if any, which) (b) (leverbeales	Certio Vascula Disease !
	gove rise to immediate cause (o), stating the under	
1	lying couse lost. (c)	The second secon
	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED?
		YES NO
	OR CONTRIBUTING CLAUSE OF DEATH	D. (Enter nature of injury in Port I or Part II of item 1B.)
	= [[ACE OF INJURY (Hame, farm, 20f. (City or town) (County) (State)
	Hour om While Not while at work of wark	
	21 I certify that (I) (this hasp/tal) attended the deceased fram.	June 21, 1960 to June 16, 1961, that (1) (we) last
	saw the deceased alive an Access 13 196 frond that d	leath accurred at 2 PM, from the cases and on the date stated above.
	220 SIGNATURE	22b. DATE
H		M.D. PHYS. DIRECTOR PHYS
	PAME (Type) Joseph & Bush MD	HAMPSTEAD Maryland
	230 BURIAY CREMATION, 236 DATE THEREOF 230 MAME OF CEMETERY OF	R CREMATORY 23d. LOCATION (City, lown, or county) (Slate)
	24 COMERAL DIRECTOR'S SCHAPORE, LEW STEEL ADDRESS CHAPORESS CHAPORESS CHAPORESS CHAPORES AND ADDRESS CHAPORES OF A CONTRACT OF THE CONTRACT OF	250. REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE DATE JAN 2 3 '61 Circling S. Huma



after death. Page 4 the funeral director, be filed

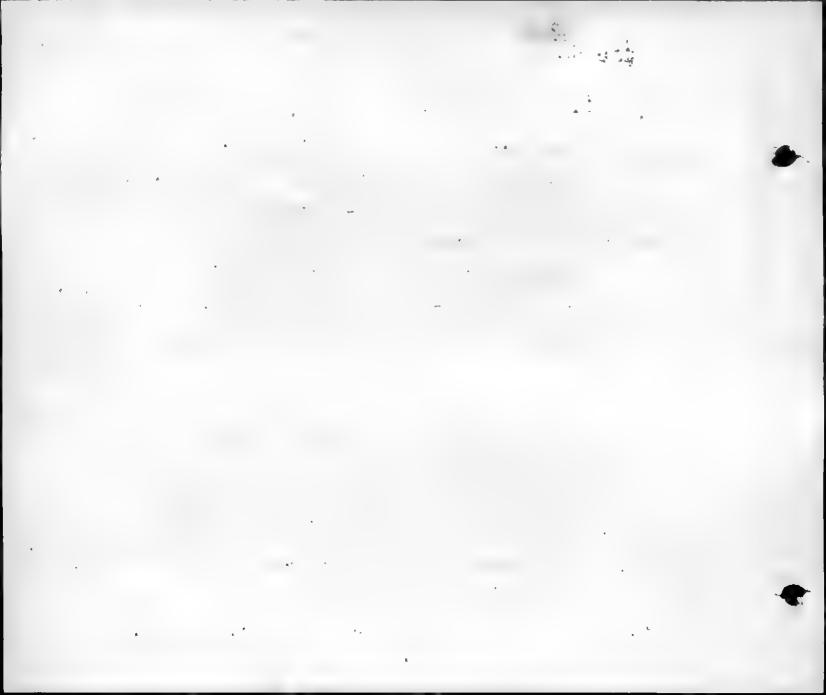
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

		3.30		CEKTIF	CAI	OF DEA	ш			Reg. D	ist. Ne.	B 4	26
1.	PLACE OF DEATH	* .		, , , , , , , , , , , , , , , , , , , ,		USUAL RESIDENCE	(Wher	e deceased			nce befar	e admis:	ston)
	6 COUNIT	Carroll		MARYLA	ND	o. STATE Mar	vla	and	b. COUNTY	Carro	011		
	b. CITY OR TOWN (IF RURAL and give ne	outside carporate limi	ıts, write	c. LENGTH OF STAY IN	16 _	c. CITY OR TOWN	(If out	side corpor	ota limits, write R	URAL and	give nea	rest tawr	n}
	Mt. Ai	,		50 yrs	- 1	Mt.	A1	ry					
	d. NAME OF HOSPITA	AL (If not in hospital, g	give street i	oddress)		d. STREET ADDRES	SS					. IS RES	SIDENCE FARM?
			7e.,			Pa	rk	Ave.					NOK
3.	NAME OF DECEASED	Fire	rst	Middle		Last	- 4	4. DATE OF	Mon	th	Đa	7	Yeor
	(Type or print)	HOWARI	D		ETCH	ISON		DEATH	Jan	. 1.	3,		1961
5	SEX	6. COLOR OR RACE	7. MARR	IED NEVER MARRIED	8. D/	ATE OF BIRTH			9. AGE (In years lost birthdoy)	Months			T
	mala.	white	WIDOWE	DIVORCED [7 7	15-18	88_		72 yrs	MORIUS	Days	Hours	Min.
100	JSUAL OCCUPATIO	IN (Give kind of work i	dane 10b	KIND OF BUSINESS OR I	NDUSTRY	11. BIRTHPLACE (S	State or	fareign co	untry)				COUNTRY
	Barber	, , , , , , , , , , , , , , , , , , , ,	"	Barber		Mary	lar	nd			U.S.		
13.	FATHER'S NAME				14	. MOTHER'S MAID	EN NA	ME					
		Wesley	y Etc	chison		Franc	es	Hoo	d				
		R IN U. S. ARMED FOR		SOCIAL SECURITY NO.	INFOI	RMANT			Add	ress		Lto	
	no		2	15-32-334 <u>2</u>	H.I	eonard	Etc	chiso	n, 406	0ak	Cot	urt,	,
			ouse per lin	ge far (a), (b), and (c).]	1 -	1		1	1 4				ETWEEN DEATH
	PART I, DEA	TH WAS CAUSED BY: IMMEDIATE CAUSE (o	and	Trioschif	tie c	wederval	محم	Ver o	belose			No	
	1423	DUE TO										1	
	Canditions, if or		1									•	
	gove rise to in couse (o), stoting t)										
	lying cause lost.	(c	:}										
CATION	PART II. OTH	ER SIGNIFICANT CON	IDITIONS <u>C</u>	ONTRIBUTING TO DEATH	ON TUS	RELATED TO THE T	ERMIN	AL DISEASE	CONDITION GIV	EN IN PAI	RT 1(o) 1	PERFC YES	DRMED?
MEDICAL CERTIFICATION	20g. ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY	S UNDERLYING [] CAUSE OF DEATH MEDICAL EXAMINER)	20b DESC	CRIBE HOW INJURY OCC	URRED (E	nter nature of snjury	y in Pa	rt I or Port	II of item 18)				
CAL	20c. TIME OF INJURY	Y Manth, Day, Yee	ar 20d. IN	NJURY OCCURRED 20		OF INJURY (Home,		20f. (City	or tawn)	(Caunty)		(State
MED	Hour a.m. p.m.	19	While of work			street, office bldg.		1,-					
	21. I certify the	at I attended the	decease	ed fram . 1.0.1.	70	, 19.5. Tra		113	, 19.6.]				
	alive an	1 -8	, 19 .	ed ., and that de	eath ac	curred at			the causes an		e date		5
	ACTUAL \	Q 1	/			/ /	Al	DDRESS (Str	reel, city or town,	state}		DA	JE SIGNÉ
	SIGNATURE	med. K	fr	~	M.D.	How	~20	Cup	, IV a			1/	1774
	PHYSICIAN'S NAME (Type)	JAMES P	. KE	RR				/	- 1 10 14 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				
22	BURIAL, CREMATION REMOVAL (Specify)	N, 22b DATE THEREC)F	22c. NAME OF CEMETE	RY OR CR	EMATORY	2	2d. LOCAT	ION (City, town,	or county)		(Sto	te)
	BURTAL	1-16-19	961	Pine G	rove			Mt.	Airy,				
23	FUNERAL DIRECTORS		With on A	ADDRESS				BY REGISTI		STRAR'S SI	GNATUI	E	
	C. M. W	<i>l</i> altz, 1	MINI	ield, Md.		DATE	JAN	1 7 '61	Class	tun 8	House		

Clathur & House

TO HOSP OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 may be wanted by the haspital or attending physician.

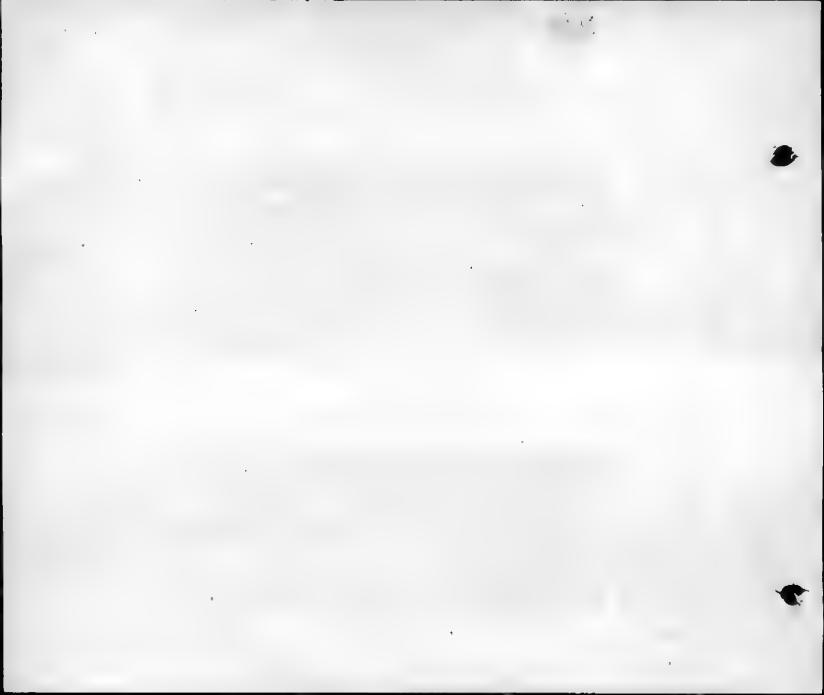
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by page 3 shauld be detached for use as the burial-transit permit. Then please remove carban pagers. Pages 1 and 2 the registrar priar to burial, cremation, ar remayal, and in any event within 72 haurs after death. VS A1S (4) 15M 9/58



VR A15 (4) 15M 9/59

66439

- 1				I			01-0-15						
		LACE OF DEATH		l Venn			2. USUAL RESID	ENCE (Wh	ere deceased	l lived. If institut		e befare adm	ission)
П		Carro	2.3		IDATE	and I	I	Maryl	and	2. 000		arroll	
	Ь		autside carporate limi	ts, write	c. LENGTH OF STAY IN	1 1b				rate limits, write l	RURAL and gi	ive nearest to	wn)
		Tanevto	מש		2 years		1	l'anev	town				
П	d	. NAME OF HOSPITA	AL (If nat in haspital, g	ive street	address)	I	d. STREET AL	DDRESS "				e. IS R	A FARM?
.3			ick Street					Frede	rick S	treet			□ NO [
Νľ		IAME OF	Fir	st	Middle		Last		4. DATE	Ma	nth	Day	Year
1		PECEASED Type or print)	Ånne		Persis		Fenlo	n	OF DEATH	January	31,	/	19 6]
-[5. S	EX	6. COLOR OR RACE	7. MARI	RIED XNEVER MARRIED	□ B.	DATE OF BIRTH	1		9. AGE (In years		YEAR IF UN	
	F	emale	White	WIDOW		_	une 21.	1889		last birthday) 71 yrs	Months	Days Hour	s Min.
	10a	USUAL OCCUPATIO	N (Give kind of wark o	ane 10b.	KIND OF BUSINESS OR				ar foreign co	ou ntry)	12, CITIZ	EN OF WHA	COUNTRY?
-			ne Operator				Brook	klam.	New Y	ork	II	S.A.	
Ì	13. I	ATHER'S NAME	ne operaco.				14 MOTHER'S	MAIDEN N	IAME	-36.4. Db.			
		Edwa	rd Fox St	even	S		Eme	line	Barry	y Jones			
	15. Y	WAS DECEASED EVER	IN U. S. ARMED FOR	CES? 16.	SOCIAL SECURITY NO.	17 INF	ORMANT			Add	dress		
		No				Edw	ard Fen	lon,	Taneyt	own, Mar	ryland		
		18. CAUSE OF DEA	TH [Enter only one co		ne far (a), (b), and (c).]					_		ONSET AN	
-		PART I DEAT	TH WAS CAUSED BY	Ca	week at 2.		2º C	a.ace	in al	Brica	4	5-2	Ha
-			IMMEDIATE CAUSE (a	1	never of he	- Contract	<u> </u>	000	1			17	
1		//0	DUE TO	_	,							10.	
1		Canditions, if ar		1 (3	ancer 1	21	Brece	rai				10 3	23
-		gave rise to in couse (a), stating t				9						1	
-		lying cause last.	(c	3									
1	Z	PART II. OTH			CONTRIBUTING TO DEAT	H BUT N	NOT RELATED TO	THETERMI	NAL DISEASI	E CONDITION G	VEN IN PART	1(a) 19. WA	S AUTOPSY
	CATIC							-					FORMED?
7	E	20g. ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY	S UNDERLYING [] [] CAUSE OF DEATH MEDICAL EXAMINER)	20b. DES	CRIBE HOW INJURY OC	CURRED.	, (Enter nature at	f injury in F	Part Lar Part	t II of item 18.)			
	3	20c. TIME OF INJURY	r Manth, Day, Ye	or 20d, I	NJURY OCCURRED 2	Oe. PLA	CE OF INJURY ()	Hame, farm	, 20f (City	ar lawn)	(C	aunty)	(State)
	MEDICAL	Haur a.m.	19	While	Nat while	tact	ary, street, affice	bldg., etc.)				
	2	p. m.			rk at wark	4	10		e-7-a .	0 2/	201	1	
-					ded the deceased f								
		22a. SIGNATURE	ed alive an Ja-	and the	219_6/ , and t	hat de	ain accurred	or Zee	M, Tram	the causes a	na an me		22b DATE
		220. SIGNATURE	Q D		0.40		ATTENDING	3 - ME	ED RECTOR [STAFF PHYS		11.11	SIGNED
		22c. PHYSICIAN'S	access of		parent	IV.	D. PHYS.		KECTOK [PH15		1116	
1		NAME (Type)	Ambler T	hom	2808		Tan	evto	wn. M	ia.			
								AT 2.2					
	230	REMOVAL (Specify)	N, 236 DATE THEREC		23c NAME OF CEMET	ERY OR	CKEMATORY		23d, LOCA	TiON (City, town,	ar county)	(5	tate)
		Burial	Feb. 3	1961	St. Josep	h's	Cemeter	'Y	Ta	nevtown.			
	24 !	FUNERAL PRECTORY	S/SHONATURE/		ADDRESS				D BY REGIST	TRAR 256, REG	ISTRAR'S SIG	SNATURE	
		C.O.Fuss	& Son	т	aneytown, Ma	ורטייו	and	DATE C	ER 6	61 (Irthur S.	House.	
		C CON YEAR	C 11	al. C	TIO'S SOMETIME WICH	on y ali	orbotal ball			0 1			



urs after death. Page 4

the funeral director, should be filled with

25 K and

TO HOSPICE. OR ATTENDING FILEYSICIAN: The low requires that the disath certificate be executed within 24 may be sined by the hospital ar attending physician.

TO ILUNIRAL DIRECTOR After this cert ficate has been signed by the attending physician and completely filled page 3 should be detached for use as the burial-transit permit. Then please remaye carban papers. Pages 1 the State Baard of Health prior to burial, cremation, ar remayal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/S9

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS - BALTIMORE 1, MARYLAND

DAKEN

	\$\$4 CERTII	FICATE	OF DEAT	Н		1441	<u> </u>
	COHNTY			Where decleased lived.	If institution: Recidence COUNTY	before admission of 199 ALC L	on)
	PITY OR TOWN (If autsider corporate limits, write RURAL and give progress forms)	IN 16	C. CITY OR JOWN (61 1	1/~	ve georest (own)	7
Si	NAME OF HOSPITAL IF not invisibility five street address / Jack Committee of the 15-42 C		d. STREET ADDRESS	und Pla	<i>ϵ</i> (e IS RESH ON A YES	FARM?
3 1	IAME OF LECEASED Type or printi LET THOU Middle		rhunde	4. DATE OF DEATH	Jeth. 3	()	961
5 \$	11/		ATE OF BUSTIN	18831 3. 1851	The Control of the Co		Min
10a.	USUAL OCCUPATION (Give kind of work done to KIND OF BUSINESS of dufins most of working life, even if retired)	fg, Co	11. BIRTHPLACE (St	ote or foreign country	12.CITIZ	EN OF WHATCO	DUNTRY?
7	seph Tolido.		not?		- lenkn	non	
)/5 (Yes	WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. or unknown; (If yes, give wor or dates of service)	17. INFO	alfliget	Actor	ellar	-00-6	
	PART I DEATH WAS CALISED BY.	•				INTERVAL BET	DEATH
	420 DUE TO		enant dina	200		Vasva	
	gave rise to immediate cause (a) stating the under-	_		d 5 G			
z	, 16)			PARIAMI DISEASE CONT	DITION CIVEN IN PART	1	1 TOPSY
ICATIO			6 - 1 1	la 1- 1 11	1	PERFOR YES 2	NO 🗌
CERTIF	OR CONTRIBUTING CAUSE OF DEATH	OCCURRED. (E	inter nature of injury	in Part I ar Part II of i	tem 18.)	,	
MEDICAL	20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED While Not while at wark at wark	20e PLACE factory	OF INJURY (Home, fi , street, affice bldg ,	arm, 20f. (City or tow	(Co	ounty)	(State)
			-26	19 <i>CO</i> , to		/ _	
	220 SIGNATURE					22b	DATE SIGNED
	22c PHYSICIAN'S NAME (Type)	M.U	22d ADDRESS			1 2 - 1	<u></u>
	Konstantin Weber			Sykesville	, Maryland		
13	removal (Specify) Feb, 2/6/ George	Yaz	hington	23d LOCATION (attantile	-, nuc	(_
24	TUNERAL DIRECTOR'S SIGNATURE ADBRESS FOR	Kali	DATE DATE	n 20 Y			
	PEDICAL CERTIFICATION 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	b effy or town (if outside coporate limits, write compared give peaces fown) Compared to the compared fown of the compared give street oddress) Compared fown of the compared for the compared fown of the compared fo	BOUNTY MARYLAND b OTTY OR TOWN (II outside consporate limits, write RURAL dod give peoplest foreby A NAME OF HOSPITAL (If got in/hipspital) give street oddress) A NAME OF HOSPITAL (If got in/hipspital) give street oddress) A NAME OF HOSPITAL (If got in/hipspital) give street oddress) B DADDESSIPPORT OF COLOR OR RACE TOWN OF DECEASED B COLOR OR RACE WIDOWED DIVORCED 100. USUAL OCCUPATION (Give kind of work done lob kind of Business OR INDUSTRY duffing might, even if retried) 13 FATHERS NAME TOWN OF THE STATE (Enter any one course per line for (o), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gove rise to immediate course (a) stating the under. Iying course last OR ONTRIBUTING OCCUPATION OR CONTRIBUTING OCCUPATION TOWN OF INJURY Month, Doy, Year While Not while at work of a work of a work of a work of a work of the deceased alive an Island of a work of while at work of a work 200. ACCIDENT WAS UNDERLYING OCCUPATED. While Not while at work of a wor	BRACE OF DEATH O. COUNTY MARYLAND B OFTY OR TOWN (II outside comporate limits, write of LENGTH OF STAY IN 16 of LENGTH OF LE	PLACE OF DEATH 0. COUNTY 1. COUNTY	PLACE OF DEATH CULTUM COUNTY CO	PLACE OF DEATH



Balto.Citv

11.

IF UNDER 1 YEAR IF UNDER 24 HRS

e. IS RESIDENCE

ON A FARM? YES NO

Year

1961

b. COUNTY

January

Months

9. AGE (In years lost birthday)

78

Frankford Ave

DATE

OF DEATH

CERTIFICATE OF DEATH I. PLACE OF DEATH 2, USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY o. STATE MARYLAND Carroll Maryland CITY OR TOWN (If autside corporate limits, write c LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town) RURAL and give nearest lown) Sykesville Byrs.llmos.7days Baltimore d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS OR INSTITUTION Springfield State Hospital 5111 Middle DECEASED death. (Type or print) Clarence Miles Foote S. SEX 6. COLOR OR RACE | 7. MARRIED | NEVER MARRIED | 8. DATE OF BIRTH ofter Male March 25, 1882 White DIVORCED | WIDOWED TO 10a USJAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11 8IRTHPLACE (State or foreign country) during most of working life, even if retired) Shipwright 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME George Foote IS. WAS DECEASED EVER IN U S ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT No 18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY Congestive failure IMMEDIATE CAUSE (o) Conditions, if any, which Myocardial infarction gave rise to immediate **DUE TO** couse (a), stating the under-Coronary arteriosclerosis lying cause lost OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FERM MALD DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY ASSOCIATED WITH COPY OF A THEORY psychotic reaction. 200. ACC DENT WAS UNDERLYING TO OR CONTRIBUTING TO CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Doy, Year 20d, INJURY OCCURRED factory, street, affice bldg., etc.) Hour o.m. While Nat while at wark p. m. at wark 21 I certify that (1) (this haspital) attended the deceased from Feb. 4. saw the deceased alive an January 11, 61 and that death accurred at 8: 10, 10 mm the causes and an the date stated above. 22a, SIGNATURE ATTENDING PHYS M D 22d ADDRESS 22c PHYSICIAN' NAME (Type) Agustin del Campo, BUR AL CREMATION, 236. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) **ADDRESS**

12. CITIZEN OF WHAT COUNTRY U.S.A. Maryland Christine -Address Springfield Hospital Records INTERVAL BETWEEN ONSET AND DEATH week week Years YES NO 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (State) (County) 19 57, to January 11, 19 61 that (I) (we) last Springfield Hospital, Sykesville, Md. (Slate) 25o, REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE

within геточе permit peen sign∎d burial-transit cremation, certificate DIRECTOR: Board 3 should FUNER

after death

poys the

Pages

papers.

filled

0 COL

15M 9/5



VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

	DIAISION OF	SIMILISHOWE	KESEPHKUTI	MIAD	VECON	D J —	DOL
4	4	CE	RTIFIC	ATE	OF	DE	ATI

-4	1	g	¥	.6	£	0
-{	4	Ę	ž	1	4	6

	444	CERTIFICA	TE OF DEATH		66526
)	1, PLACE OF DEATH		2. USUAL RESIDENCE (Whe		on: Residence before admission)
	6. COUNTY Carroll	MARYLAND	o. STATE	b. COUNTY	January 17
	b. CITY OR TOWN (If outside corporate limits, write	c. LENGTH OF STAY IN 16		utside corporate limits, write R	URAL ond give nearest fown)
	RURAL and give nearest town)		3/1		<u>-</u>
Į	d NAME OF HOSPITAL (If not in hospital, give street	et oddress)	d. STREET ADDRESS	Taneytown	e. IS RESIDENCE
5.	OR INSTITUTION	ur waar waar	d. STREET ADDRESS		ON A FARM? YES NO A
	3. NAME OF First DECEASED	Middle	Last	4. DATE Mon	/
	(Type or print) Kenneth	Franklin	Frock	DEATH Januar	y 15. 1961
	S. SEX 6 COLOR OR RACE 7. MA	RRIED W NEVER MARRIED	B. DATE OF BIRTH	9. AGE (In years lost birthday)	Months Doys Hours Min.
	mate Hille	WED DIVORCED	A A A A A A A A A A LAND	915 45 yrs.	
	10a USJAL OCCUPATION (Give kind of work done 10 during most of working life, even if retired)	b. KIND OF BUSINESS OR INDU	STRY 11. BIRTHPLACE (Stote (or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	Service Station Operato	ገ ግ	Maryland		U.S.A.
	13 FATHER'S NAME		14 MOTHER'S MAIDEN N	AME	
\	Jesse W. Frock		Sarah	Fink	
	15. WAS DECEASED EVER IN U. S. ARMED FORCES? 1	6. SOCIAL SECURITY NO. 17. I	NFORMANT	Add	ress
,	(Yes, no, or unknown) (If yes, give wer or dates of service)	340 34 5021 N	lun Cakhanina	Prople Bonnet	1/2
	18. CAUSE OF DEATH [Enter only one couse per		lrs. Catherine	rrock, raneyi	INTERVAL BETWEEN
	PART I, DEATH WAS CAUSED BY:	1	A . I	B-1	ONSET AND DEATH
	IMMEDIATE CAUSE (o)	cute Coro	hary Hrt	ery crue	3104 FEW MIN
	DUE TO		1	1	
	Conditions, if ony, which (b)				
	gove rise to immediate DUETO				
	lying couse lost. (c)				
	PART II. OTHER SIGNIFICANT CONDITION	S CONTRIBUTING TO DEATH BU	T NOT RELATED TO THE TERMI	NAL DISEASE CONDITION GIV	VEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED?
	3 Huberte	43104			YES NO
	20g. ACCIDENT WAS UNDERLYING TI 20b. D	ESCRIBE HOW INJURY OCCURRI	ED. (Enter noture of injury in P	ort or Port of item 18.}	
		La Caración de la Car	IACE OF INJURY (Home, form, octory, street, office bldg., etc.		(County) (Stote)
	Hour o. m. 19 Whi	ils Not while or work of two	1		
	21 I certify that (I) (this haspital) atte	nded the deceased from	7/6 105	K to 1/15	1961, that (I) (we) last
	saw the deceased alive an 12-12			M from the courses or	nd an the date stated above
	220 SIGNATURE		deally accorded of 135%	pri, irdiii (ije cooses oi	22b.DATE
	OC. D. mei	laugh	M. D. PHYS ME	D. STAFF	1/16/61 SIGNED
	122c PHYSICIAN'S NAME (Type) R S M	Mariala	22d. ADDRESS	7	- Ind
			1000	agura	
	230 BURIAL, CREMATION, 236 DATE THEREOF REMOVAL (Specify)	23c NAME OF CEMETERY	OR CREMATORY	23d LOCATION (City, town,	or county) (State)
	Burial Jan. 18, 196	1 St. Joseph's	Gemetery	Taneytown.	Maryland
	24. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC't		ISTRAR'S SIGNATURE
	6.0.Fuss & Son. Tanes	town. Maryland	DATEIAN	1 9 '61	La & France



VR A1S (4) 1SM II/S9

MARYLAND	STATE DEI	PARTMENT	OF HEAD	LTH
ON OF STATISTICAL	RESEARCH AND	RECORDS - B	ALTIMORE 1,	MARYLAND

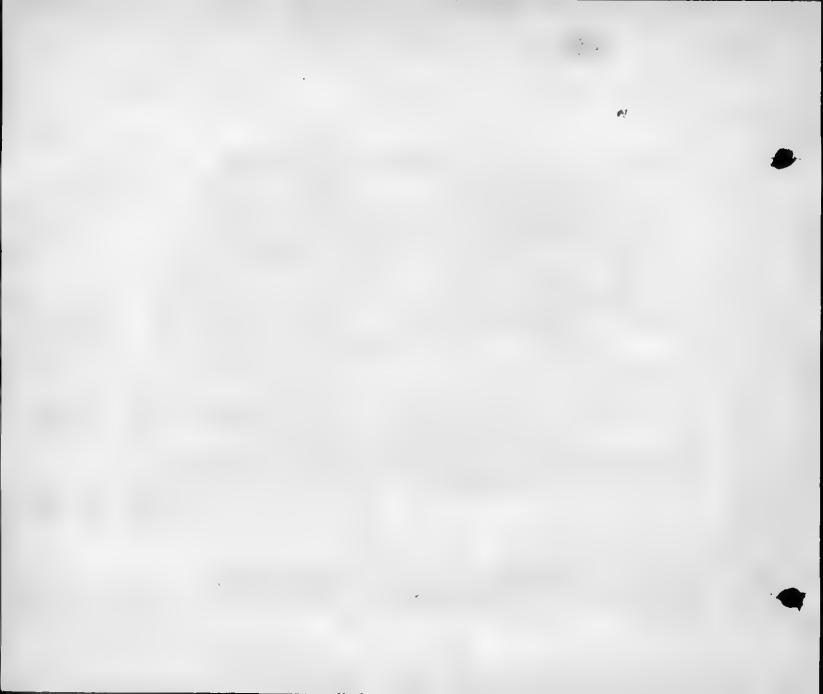
445 DIVISION CERTIFICATE OF DEATH

(10443

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institutions Residence before admission) o. STATE b. COUNTY					
Carroll	ARYLAND	Maryland Frederick					
b. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town) Sykesville LENGTH OF ST LYT.6mos		c CITY OR TOWN (If autside carporate limits, write RURAL and give nearest tawn) Thurmont					
d. NAME OF HOSPITAL (If not in hospital, give street oddress) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS # 1 I S RESIDENCE ON A FARM? YES ON OF					
3. NAME OF First Mid DECEASED (Type or print) Fannie Florence	Sweer	ny Geisbert January 13, 1961					
S SEX 6. COLOR OR RACE 7. MARRIED NEVER MA	RRIED 🔲	8 DATE OF BIRTH 9 AGE (n years IF UNDER 1 YEAR IF JNDER 24 HRS lost birthdoy) Manths Days House Min					
Female White WIDOWED DIVOR	RCED 🔲	December 27.1881 79 yrs Manths Days Hours Min.					
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	S OR INDUS	JSTRY 11 BIRTHPLACE (Stole or foreign country) 12 CITIZEN OF WHAT COUNTRY? Maryland U.S.A.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
William Sweeny		America Amelia Lightner					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY	NO. 17 IN	NFORMANT Address					
No -		Springfield Hospital Records					
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and PART I. DEATH WAS CAUSED 8Y: IMMEDIATE CAUSE (a) DUE TO		INTERVAL BETWEEN ONSET AND DEATH					
Canditions, if ony, which gove rise to immediate cause (a), stating the underlying couse loss (c) Diabetes							
5	DEATHLBUT OSCIET	TNOT BELATED TO THE TERMINAL DISEASE COND TION GIVEN IN PART 1(a) 19 WAS ALTOPSY PERFORMED? YES NOTE:					
CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	Y OCCURRE	ED. (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED While Nat while at wark of wark		LACE OF INJURY (Hame, farm, 20f. (City or town) (County) (State) actory, street, affice bldg., etc.)					
		June 17, . 1959, ta January 13, 1961, that (I) (we) last death accurred a8:154Mram the causes and an the date stated above.					
220 SIGNATURE Raymond Ilal	luc.	MD ATTENDING MED STAFF 1/13/81					
22c PHYSICIAN'S NAME (Type) J. Raymond Gladue, M.D.	•	Springfield Hospital, Sykesville, Md.					
230 BURIAL, CREMATION, 236 DATE THEREOF 23c. NAME OF CREMOVAL (Specify) BURIAL JAN 2 T96T Utica 24 FYNERAL DIRECTOR'S SIGNATURE ADDRESS	Cem.	Utica.Fredk.Co.MD 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE					
Jaymond Griager Thu	rmont	t. MD DATEJAN 1 6 '61 Circling S. France					



MARYLAND STATE DEPA	ARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 30	ERTIFICATE OF DEATH
HEALTH DEDT	
a. COUNTY	USUAL RESIDENCE (Where deceased fived, If institution; Residence before admission)
a. COUNTY ARROLL MARYLAND b. CITY OR TOWN (If outside corporete limits, write RURAL and give nearest lown) VIARS X	MARYLAND CARROLL
b. CITY OR IOWN (if outside corporate l.mils, write RURAL and give nearest lown) NEW WINDSOR X ARS	c, CITY OR TOWN (if outside corporate limits, write RURAL and give narrast town)
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	d. STREET ADDRESS IS RESIDENCE
6 2 6 16/11/11	ON A FARM?
The state of the	Last 14. DATE Month Dey Yeer
DECEASED (Type or print) JAMES MONKOL CAR	PLIN DEATH JAN 26 1961
5. SEX 6. COLOR OR RACE 7. MARRIED B. DAT	TE OF BIRTH 9. AGE (In yaers IF UNDER 1 YEAR) IF UNDER 24 HRS.
Pulled Divorced JC'L	14-1919 Months Days Hours Mn.
10a. USUAL OCCUPATION (Give kind of work 1Db. KIND OF BUSINESS OR INDUSTRY 11.	BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?
done during most of working life, even if retired) N. BBER FAITURY	MARYLAND USA
13. FATHER'S NAME 14. 14. 15. 16. 17. 18. 18. 18. 19. 19. 19. 19. 19	MOTHER'S MAIDEN NAME
** \$4	SARAH BAILE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFO	
DEEEE 2 NC 2/5 32 -46/3 1/27	IE GREEN NEW VYINDSOR MA
DANIE DESCRIPTION OF THE PROPERTY OF THE PROPE	INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (e)	ELLITUS YEARS
DUE TO Conditions, if any, which (b)	/
gava risa to immediate cause	
(a), stating the underlying DUE TO cause last. (c)	
0 6 F 6 3	ATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY
P P P P P P P P P P P P P P P P P P P	PERFORMED? YES NO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT REL.	natura of injury in Part I or Part II of Itam 18.)
CAUSE OF DEATH	
20c. TIME OF INJURY Month, Dey, Year 2Dd, INJURY OCCURRED 2De, PLACE Of While at work 10 fectory, st 20c. TIME OF INJURY Month, Dey, Year 2Dd, INJURY OCCURRED 2De, PLACE Of While at work 10 fectory, st 20c. TIME OF INJURY Month, Dey, Year 2Dd, INJURY OCCURRED 2De, PLACE Of While at work 10 fectory, st 20c. TIME OF INJURY Month, Dey, Year 2Dd, INJURY OCCURRED 2De, PLACE Of the remains described above, held at	F INJURY (Home, farm, 20f. (City or town) (County) (Stella)
Hour a.m. P.m. While Not While at work at work at work	
21. I certify that I took charge of the remains described above, held ar	
death resulted from: Natural causes , Accident . Suicide [, Homicide , Undetermined manner
ACTUAL SIGNATURE LA MES 1 MINER	CHIEF MEDICAL EXAMINER
SIGNATURE ALLE	A.D. ASSISTANT MEDICAL EXAMINER DATE SIGNED
PRIMARY OF CONTRIBUTING CAUSE OF DEATH 2D. TIME OF INJURY Month, Dey, Year While Not While States of States of Death 2D. TIME OF INJURY Month, Dey, Year While Not While States, States of Death 2D. TIME OF INJURY Month, Dey, Year While Not While States, States of	DEPUTY MEDICAL EXAMINER Addrass (Street, city, town, o county)
1 22a, BURIAN CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREM	- Uprodev -
ON THE BURIAL 1/24/61 PIPE CREEN	CARROLL CO MD
VS. A15ME 23, FUNERAL DIRECTOR ADDRESS	248. REC'D BY REGISTRAR 246. REGISTRAR'S SIGNATURE
5M 7/59 CHARLET TAPAR HUST WINDOW	1 DATHAN 31 '61 Orthur S. Krous



ARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS. 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Whata dacassed lived. If institution: Residence before admission) of director. Page for your files. a. COLINTY **b.** COUNTY Carroll MARYLAND Balto City b. CITY OR TOWN (if outside corporate limits. e. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outs da corporata limits, write RURAL and give nearast town) write RURAL and give neerest town) 5yrs.3mos.28days Sykesville Baltimore 5 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give streat address) d. STREET ADDRESS . IS RESIDENCE meral ON A FARM? Springfield State Hospital YES NO Highland J. NAME OF 4. DATE DECEASED OF (Typa or print) DEATH Catherine Warehime Harman Januarv 6. COLOR OF RACE TY, MARRIED NEVER MARRIED | B. DATE OF BIRTH 9. AGE (In years | FUNDER 1 YEAR F UNDER 24 HRS. last birthday) Months Female WIDOWED [February IDe. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? dona during most of working life, even if retired) Housewife U.S.A. Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Charles Warehime Jane Warehime 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yes, no, or unkown) | (Ifyes give war or dales of service) No Springfield Hospital Records. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c), INTERVAL BETWEEN ONSET AND DEATH PART I, DEATH WAS CAUSED BY-Bilateral bronchopneumonia. IMMEDIATE CAUSE (a) Arteriosclerotic heart disease. Years. Conditions, if any, which gave rise to immediate cause DUE TO (a), stating the underlying causa lest. PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINA, DISEASE CONDITION GIVEN IN PART 1181, 19, WAS AUTOPSY C.B.S. assoc. with circ. dist. with cerebral arteriosclerosis with PERFORMED? should be forwarded to the Chief Medical FUNERAL DIRECTOR: Page 3 should be YES 🛣 NO psychotic reaction.

20s. EXTERNAL CAUSE WAS

20b. DESCRIBE HOW INJURY OCCURED, (Enlor nature of injury in Part I or Part II of Itam 1B.) PRIMARY [] or CONTRIBUTING [] Patient's leg gave way and she fell to floor of ward. CAUSE OF DEATH 20d, INJURY OCCURRED | 2De, PLACE OF INJURY (Homa, form, 1 20f. (City or lown) 20c. TIME OF INJURY Morth, Day, Year factory, street, office bldg., etc.) While Not While al work at work Hospi tal Svkesville Carroll 21. I certify that I took charge of the remains described above, held an Autopsy | Inspection Inquiry [and in my opinion death resulted from: Natural causes Accident . Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL ASSISTANT MEDICAL EXAMINER DATE SIGNED SIGNATURE 1/16/61 James T. Marsh. M.D. Addrass (Street, city, town, or county) 228. BURIAL, CREMATION, 225. DATE THEREOF 226. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or country) REMOVAL (Specify) <u>v</u>40 VS. A15ME 5M 7/59



CERTIFICATE OF DEATH

COMAR

1			340									U	U X 2	21/	
Enand	1. PLACE OF DEATH a COUNTY Garroll MARYLAND						2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE Maryland b COUNTY Washington Co. 21								
	b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville 5 days					IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland								
gel ^{pt}	d. NAME OF HOSPITAL (If not in hospital, give street oddress) OR INSTITUTION Springfield State Hospital.						d. STREET ADDRESS 512 Cumberland						e. IS RESIDENCE ON A FARM? YES NO		
	3. NAME OF DECEASED (Type or print)		Frisby		Middle Tilgman		los Hassett		4. DATE OF DEATH	Mor 1	ith	Doy 1		961	
	5. 5	Male	6. COLOR OR RACE White	7. MARI WIDOW	RIED NEVER MARRIE	_	3-5-187			9. AGE (In years last birthday) 81 yrs	IF UNDER Months	1 YEAR Doys	Hours Hours	R 24 HRS. Min.	
	10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDU- during most of working life, even if retired) Contractor				R INDUSTRY							S.A.			
	13.	13. FATHER'S NAME John C.Hassett					4 MOTHER'S	MAIDEN N	Sal	ly J.Co	uton				
	_								Dar						
	(Yos	WAS DECEASED EVI	R IN U. S. ARMED FOR (If yes, give wor or dates of s	CES? 16.	SOCIAL SECURITY NO.	. 17, INFO	RMANT Hospit	tal re	cords	Add	ress				
	IB. CAUSE OF DEATH Enter only one cause per line for (o), (b), and (c)										INTERVAL BETWEEN		WEEN		
	PART I. DEATH WAS CAUSED BY. Antemioscientic Hount disease and										ET AND	DEATH			
MMEDIATE CAUSE (6) Nephro-sclerosis											Jears				
	Generalized arteriosclerosis									yezas					
		gove rise to i	mmediote (]			,0,0401.0								
		cause (a), stating the <u>under:</u> lying cause lost. (c)													
	CATION										/EN IN PAR	PART I(a) 19 WAS AUTOPSY PERFORMED? YES NO			
	CERTIFICATION	20a. ACC.DENT W. OR CONTRIBUTING (IF EITHER, NOTIFY	AS UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER)	20b. DES	CRIBE HOW INJURY OF	CCURRED. (Enter noture of	Finjury in I	Port I ar Port	If of item 18)					
	MEDICAL	20c. TIME OF INJUI Hour a.m. p. m.	RY Month, Day, Ye	While			OF INJURY (I			or fown)	(1	County)		(Stote)	
_d	21 I certify that (I) (this haspital) attended the deceased fram. 12-27- 1960, to 1-1-61, 1961, that (I) (we saw the deceased alive an 1-1- 1961, and that death accurred 2.30%, from the causes and an the date stated of														
/		22o 5 GNALJRE 22b. DA										DATE			
								M.D. ATTENDING MED. STAFF TO 1-15196							
		22c PHYSICIAN'S NAME (Type)	Agustin	del C	ampo. M.D.	•	Sprin		d Stat	e Hospit	al Sy	kes	ville	Md.	
	2 3a	BUR AL CREMATIC REMOVAL (Specify	JAN 5	1961	23c NAME OF CEME	ETERY OR C	REMATORY METER	٢	23d LOCAT	ON (City town, RSPRIN	or county)	7	h D	:)	
	24,	FUNERAL DIRECTOR	'S SIGNATURE		QEASTOW.				D BY REGIST	RAR 25b. REGI	STRAR'S SI	GNATUR	E		
*	-		DOUZER		C D71 37 000.		*	DATEAN	4 '61	Qu	wa 8. 1	Trava			

may be in fined by the haspital or attenting physician.

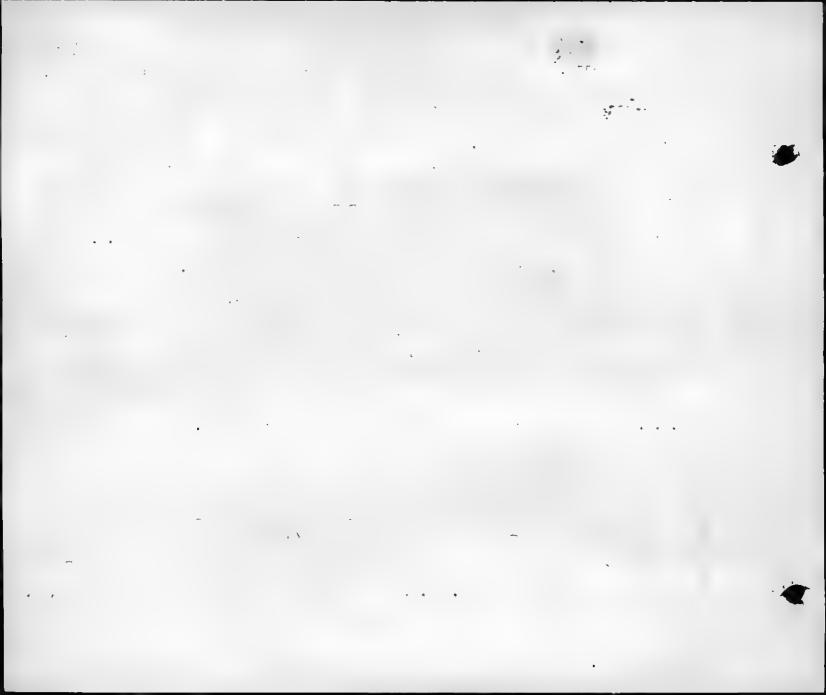
TO FUNERAL DIFFITOR: After this mertificate has been signed by the attending physician and campletely filled page 3 shmuld lie detached for use as the burio-transit permit. Then please remave carbon papers. Pages 1 the State Board of Health prior to buriol, cremotion, mr mmmval, and im any event, within 72 hours often leath. TO HOSP VR A1S (4) 1SM 9/S9

the attending physician and campletely filled with the funeral director. Then please remave carbon papers. Pages 1 and 2 should be filed with

s after death. Page 4

IN ATTENDING ENTITIONS: The law requires that the death scrifficate be executed within 21

(3)



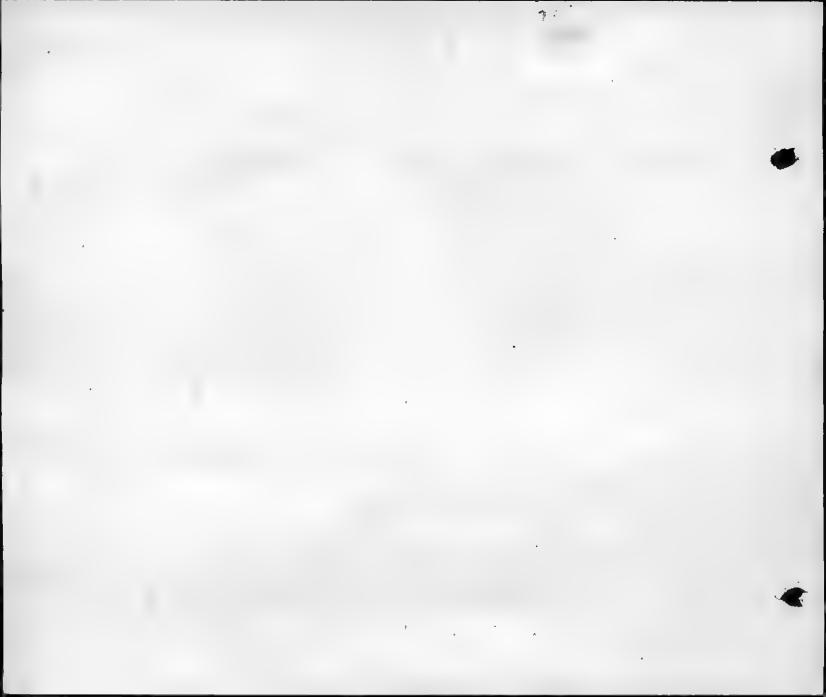
s after death. Page 4

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24

TO HOSE

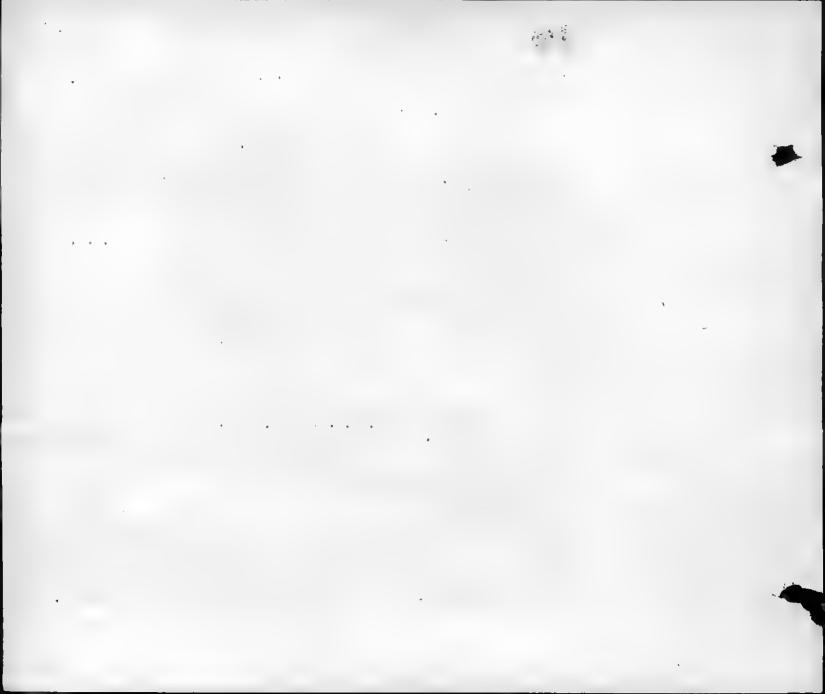
VR A15 (4) 15M 9/59

		223		CERTIFIC	ATE O	F DEATH	1			11	447
1	PLACE OF DEATH				0 51	AL RESIDENCE (VA	here deceased	lived If institute b. COUNTY	on: Residence	before adm	nission)
	Carr	011		MARYLAND	<u>' </u>	Marylar	nd		Carro	11	
	b. CITY OR TOWN (I RURAL and give re	f outside corporate limitearest fown]	its, write c	LENGTH OF STAY IN 1	30° C	ITY OR TOWN (IF	outside corpor	ote limits, write R	URAL and give	e nearest to	wn)
L	Rural T	anevtown		5 days		Rural V	Vestmin	ster			
	d. NAME OF HOSPIT OR INSTITUTION	AL (If not in hospitol, s	give street addr	ess)	/ d. 9	TREET ADDRESS				e. IS F	ESIDENCE
		e #2 Tanev	hown			Pleasa	t Vell	p.17			□ NO J
3	NAME OF	Fit		Middle		Last	4. DATE	Mon	th	Day	Yeor
	(Type or print)	Bertha	9	Louise	H	elwig	DEATH	Januar	77	24	19 61.
5	SEX			NEVER MARRIED		OF BIRTH		9 AGE (In years	IF UNDER TY		4- 400
	70 7 -		WIDOWED [1_		1001	lost birthdoy)	Months Do	ys Hou	rs Min.
0	Female	White		OF BUSINESS OR INI	Janua		1884	76 yrs.	12 CITIZE	N OF WHA	T COUNTRY
10	during most of worl	sing life, even if retired) _		JUSIKI III.						I COOMIK
	Housewif	е	Ow	n home	-	Carroll			U.	S.A.	
18	. FATHER'S NAME				14, M	OTHER'S MAIDEN	NAME				
	Aaron	Freeland He	eltibri	dle		Sarah	Ellen	Formwa]	t		
		R IN U. S. ARMED FOR		IAL SECURITY NO. 17	INFORMA	TV		Add	ress		
1.	No	fit has' flitte wat an entire or i	nar vroat	N	rs. L	eroy Helv	wip.19	Rita Mar	ie. Li	ttles	town.
	TIE. CAUSE OF DEA	TH [Enter only one co	ouse per line fo								BETWEEN
		TH WAS CAUSED BY.	100	0		- a	Tim.	Coco Os	14120.	ONSET A	ND DEATH
	1010	IMMEDIATE CAUSE (d		Re Care	2000	sup-c	arcy -	Ç		1420)-
	-00	DUE TO	A.	Timing	1-11.		110-	777	t	5	L1-
L	Conditions if a		1 6 2 79	. cereny	ريمين	rolic	14-000	1 yes	all		- pra
	couse (a), stating		D. V	- 700 m	100	chr.	. , .	1001	_ ``	-1-	1
l_	lying couse lost.	} (0	LICEL	exca pres	uu	a struct	romay	W67774	enios		0513
ATION	PART II OTI	HER SIGNIFICANT CON	IDITIONS CON	TRIBUTING TO DEATH B	UT NOT REL	ATED TO THE TERM	AINAL DISEASE	CONDITION GIV	EN IN PART 1		S AUTOPS'
A										YES	NO 🖺
TIE	200. ACCIDENT W	AS UNDERLYING TO CAUSE OF DEATH	20b. DESCRIB	HOW INJURY OCCUR	RED, (Enler	nature of injury in	Port I or Port	Il of item 18.)			
CERT	(IF EITHER, NOTIFY	MEDICAL EXAMINER)									
A	20c. TIME OF INJUR	Y Month, Doy, Ye	or 20d. INJUR	Y OCCURRED 20e.	PLACE OF I	NJURY (Home, for	m, 20f. (City	or town)	(Cor	inty)	(Stote
MEDICA	Hour o.m.	19	While of work	Not while of work	foctory, stre	el, office bldg., e	tc.)				
2					4/0	0	1/4	1/24	-/1		
	21. I certify the	ıt (I) (Mais hospit a	attended	the deceased from		- 2 1	97.00 ta	4-6-7		,) (we) la
	saw the decea	sed alive an	<u> </u>	_1962 / and tha	t death a	ccurred 4:5	g M, fram	the causes an	d on the c	ate stat	
	220 SIGNATURE	1671	10/10	/	AT	TENDING	LED	STAFF		1	22b)DATE SIGNE
	K	- 7 16	P. CYEE	cape -	M.D PH	Y5.	DIRECTOR .	PHYS 🗌		1/2-5	161
	22c PHYSICIAN'S NAME (Type)	RCL	1.11.		220	ADDRESS	~	1-	- 4	1	/
		ハ・スパ	1eva	094		10	ne	ren	u,	ua	
23	a. BURIAL, CREMATIC	IN. 23b. DATE THEREO	OF 23	C NAME OF CEMETERY	OR CREMA	TORY	23d LOCA	ION (City town,	or county)	(5	lote)
	REMOVA. (Specify)	Jan. 28.		St. Mary's					Carrol	7 Ma	rvlan
24	FUNERAL DIRECTOR	S. SIGNATURE.	47941	ADDRESS	Actio 0		C'D BY REGIST		STRAR'S SIGN		7 7 GT
	C.O.Fuss	17 A Rills	To	neytown,Mar	hastra	DATE	JAN 26		The &		
L	- U.U.I uss	O. DUII	18	ney town, war	yrand	DAIL	BMH T a				



after death. Page

ŏ



451

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

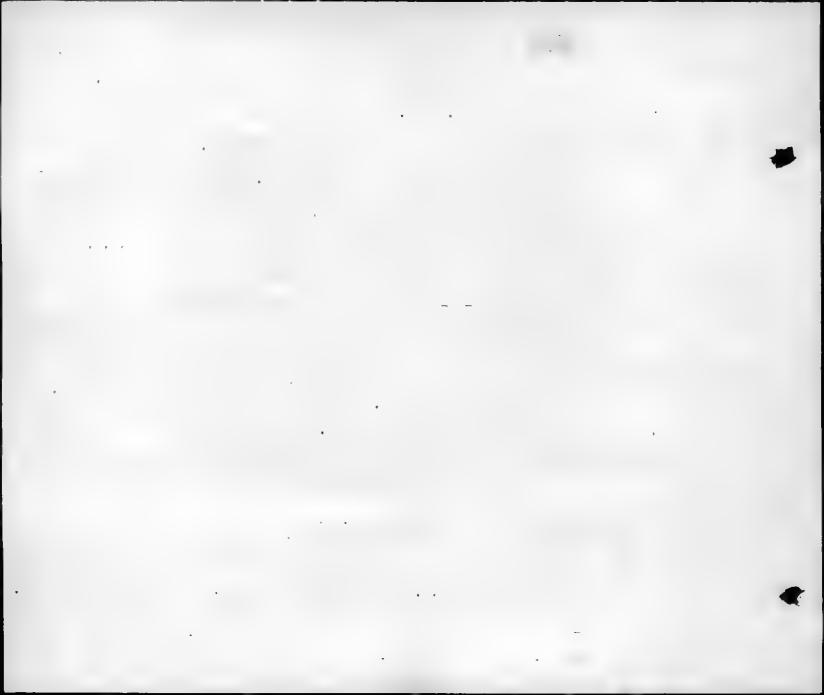
60449

1 PLACE OF DEATH a. COUNTY Carroll MARYLANT					2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) o. STATE Maryland b. COUNTY Balto.City						
-	b. CITY OR TOWN (If o	utside corporate limits, wr	ite c LENGTH OF STAY IN	136	c. CITY OR TOWN (hents, write RUR				
	RURAL ond give near	2yrs.llmos.	8day	s Balt	timore 13		2 1	- 1			
		(If not in haspital, give st			d. STREET ADDRESS				el IS RE	SIDENCE A FARM?	
		eld State Ho	spital		1769	Darley S	t			NO	
	NAME OF DECEASED	First	Middle		Lost	4. DATE OF	Month		Day	Year	
_	(Type or print)	George	Alfred		Hubbard,	Sr. DEATH	Januar	V	9,	1961	
S	SEX	COLOR OR RACE 7.	MARRIED NEVER MARRIED		DATE OF BIRTH		ast birthday) N		YEAR IF UND		
_	Male	STATE MAY	OWED TO DIVORCED		June 8, 189	₹8	62 yrs.				
100	JSUAL OCCUPATION during most of working	(Give kind of work dane g life, even if retired)	106. KIND OF BUSINESS OR	INDUSTR	Y 11, BIRTHPLACE (Se	ate or fareign count	(7)	112 CITIZE	N OF WHAT	COUNTRY?	
	Electric	ian			Maryla			U.S	3.A.		
13.	FATHER'S NAME				14. MOTHER'S MĀIDEI	N NAME					
}		rd Hubbard			Ida Mar	<u>ie Stalli</u>	ng				
15 (Ye		N U. S. ARMED FORCES? yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17, INFO		Techtel	Address	5			
	No		213-10-3401	201	ringfield l	TOSPICAT	racorda				
			per line for (a), (b), and (c).]						INTERVAL B		
PART I. DEATH WAS CAUSED BY: Acute purulent moningitis									Days		
41 C) DUE TO											
	Conditions, if ony		Infected embol					Days			
	couse (a), stating the	under DUE TO	e and neck				Month	S.			
~	lying couse lost (c) Bronchopneumonia Days										
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GI A.B.S. associated with alcohol intoxication.								I IN PART	PERF	ORMED?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19 W PI A. B. S. associated with alcohol intoxication. 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER; 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED For PLACE OF INJURY (Hame, farm, 120 f. (City or town) (County) While Not while of work of work of work of work of work.											
									unty)	(Stote)	
	21 1 certify that	(I) (this haspital) at	tended the deceased fr	ram_F	eh. 1.	19.58, toJar	uary 9.	. 1951	_, that (I)	(we) last	
	21 1 certify that (I) (this haspital) attended the deceased from Feb. 1, 1958, to January 9, 1961, that (I) (we) last saw the deceased alive on Jan. 8, 1961, and that death accurred as: 30 MM from the causes and an the date stated above										
	220. SIGNATURE 22b. DATE SIGNED STAFF SIGNED										
	22c PHYSICIAN'S	went al	- Chinitie	M.E	22d. ADDRESS	DIRECTOR L	PHYS &		1./	7/01	
	NAME (Type)	Agustin de	lCampo, M.D.		Springfi	eld State	Hospita	1, S	ykesvi.	lle,Mc	
23	BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c. NAME OF CEMET	ERY OR C	CREMATORY	23d. LOCATIO	N (City, town, or	caunty)	(Sto	ote)	
_	Burial	1-11-1961	Baltimor	10			ore, Mary				
24	FUNERAL DIRECTOR'S !		901 Eastern Av	7.0		EC'D BY REGISTRA	25b, REGISTI	RAR'S SIGN	VATURE		
	PITITA & Ye.	TTGI. THO T	YOU END DELIL W		DATE	JAN 1 1 '61	CI	1 0	de		

may be Conned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in the funeral director, page 3 should be detached far use as the burial-transit permit. Then please remove carban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, crematian, ar remayal, and in any event, within 72 hours after death. is after death. Page 4 OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 TO HOSP

VR A1S (4) 1SM 9/59



FOR STATE HEALTH DEPT TO DENOTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a selection is necessary, please execute the certificate, writing the word "pending" in pendi in from 18. Give Page A. 2, and 3 to the Toneral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages I and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 452 MEDICAL EXAMINER'S CERTIFICATE OF DEATH $\{, \{\}45\}\}$

1	1. PLACE OF DEATH 6. COUNTY	-		2. USUAL RESIDENCE (V	Where deceased lived, If institution b. COUNTY	Residence before edm ssion)
-	b. CITY OR TOWN (if write RURAL end	pulside corporate limits,	c. LENGTH OF STAY IN 16	Maryla		rroll and give neerest town)
	Taneytown	L AL OR INSTITUTION (if not in ho	10 years sp.iel, g ve sireet eddress)	d. STREET ADDRESS	own	is residence On A FARM?
	231 E. B 3. NAME OF DECEASED (Type or print)	alt <u>imore</u> Street	Middle	Losi 4,	Raltimore Street	YES NO NO Yeer
-		Charles	Thomas D NEVER MARRIED 8	Humbert DATE OF BIRTH	P. AGE (In yeers If UNDER lest birthdey) Months	
	Male 10e. USUAL OCCUPATIOn done during most of work	White WIDOWI		arch 27, 1910	50 yrs.	ITIZEN OF WHAT COUNTRY?
	Plumber 13. FATHER'S NAME	O _W	n shop	Maryland	I II	.S.A
-	Herber 15. WAS DECEASED EVER (Yes, no, or unkown) (If)		SOCIAL SECURITY NO. 17. 1	Gertrude F	Boyd Address	T MAC
	no.	ATH [Enter only one cause per	3-01-3190 M	iss Nellie Humb	ert, Taneytown,	Maryland
		WAS CAUSED BY: AMEDIATE CAUSE (6)ACU DUE TO	te Coronary	Artery Occlu	sion	Few minutes
	Conditions, if eny,	which (b)				
1	geve rise to immedial (e), stating the uni	> DUE TO				
1	cause lest.	(c)	ITPIDITING TO DEATH BUT NO	OT DELATED TO THE TERMINAL D	ISEASE CONDITION GIVEN IN PA	
			NINBOTH TO DEATH BUT NO	A KETATED TO THE TERMINAL D	ISEASE CONDITION GIVEN IN PA	PERFORMED?
- 1			BE HOW INJURY OCCURED. (I	inter neture of Injury in Pert I or	Perf il of item 18.)	
	20c. TIME OF INJUR Hour e.m. p.m.	White		CE OF INJURY (Home, form. 20 ory, street, office bldg., etc.)	Of. (City or town) (Co	ounty) (Stete)
	21. I certify tha	t I took charge of the rem	nains described above, he	ld an Autopsy . Insp	ection X. Inquiry	and in my opinion
	death resulted fro	om: Natural causes	Accident . Suic	ide, Homicide CHIEF MEDICAL EXAM	Undetermined manner	
	ACTUAL SIGNATURE	11.11. M9	laugh	M.D. ASSISTANT MEDICAL	EXAMINER [DATE SIGNED
	EXAMINER'S NAME (Type)	R. S. McVaus	rh		MINER Acting	1/3/61
2	20. BURIAL, CREMATION REMOVAL (Specify)		226. NAME OF CEMETERY OF		LOCATION (City, town, or count	(Stelle)
-	Burial 23. FUNERAL DIRECTOR	1/4/61	Reformed Cemet	ery Te	neytown Maryla REGISTRAR 246. REGISTRAR'S	nd SIGNATURE
	C.O.Fuss &		town, Maryland	DATE JAN		8. Hraud



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH Reg. Dist. No. director, iled with PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. COUNTY filed **b.** COUNTY MARYLAND funeral b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give neorest town should d. NAME OF HOSPITAL (If not in hospital, give street oddress) IS RESIDENCE d. STREET ADDRESS OR INSTITUTION ON A FARM? O. YES ANO NAME OF Middle 4. DATE Lost Month Day Yeor Filled DECEASED (Type or print) RO ARCHIBAL DEATH 19 6 5. SEX 6. COLOR OR RACE 7. MARRIED THEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthdoy) Months Days WIDOWED [DIVORCED | yrs. cample 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 12. CITIZEN OF WHAT COUNTRY? pa pup pau 13. FATHER'S NAME physician 8 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO INFORMANI 72 aftending 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c)." INTERVAL BETWEEN ONSET AND DEATH ā PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) **DUE TO** Conditions, if any, which signed gove rise to immediate DUE TO couse (a), stating the underlying couse lost. burial-transit has been PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c) 19. WAS AUTOPSY navai, PERFORMED? YES NO | CERTIFIC 20g ACCIDENT WAS UNDERLYING OF CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of I em 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, 20e. PLACE OF INJURY (Home, form, 20f. (City or town) Day, Year 20d. INJURY OCCURRED (County) (State) factory, street, office bldg., etc.) Hour a.m. While Not while at work at work p, m 21. I certify that I ottended the deceosed from __.that I lost sow the deceosed and that death occurred at 215 A.M. from the causes and on the date stated above. FUNERAL DIRECTOR: ACTUAL SIGNATURE shauld PHYSICIAN'S NAME (Type) 22o. BURIAL, CREMATION, 22b, DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (Stote) REMOYAL (Specify) 2 23. EUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Cirthur S. Kines

YS A15 (4)



MARYLAND	STATE D	EPARTMEN1	OF HEA	LTH
DIVISION OF STATISTICAL	RESEARCH AN	ND RECORDS I	BALTIMORE 1	I, MARYLAND

		454			ERTIF	ICA	TE C	F DEATH				()	0452
1,	PLACE OF DEATH o. COUNTY Cari	coll			MARY	LAND		AL RESIDENCE (WITATE		ed lived, if institu b. COUNT		ence before	odmission)
	b. CITY OR TOWN (If RURAL and give ne	outside corporate limi orest town)	s, write	c LENGT	H OF STAY	IN 1b	c. C	ITY OR TOWN (IF	outside corp	orate limits, write	RURAL an	d give neares	st town)
	Sykesvill				s13	day		Frederic	.k			10 1	/· ·
	OR INSTITUTION	AL (If not in hospital, g					d. :	Montevue	Home				IS RESIDENCE ON A FARM? (ES NO NO
3.	NAME OF DECEASED	Fin	_		Middle			Last	4. DATE	Mo	mIh	Day	Year
	(Type or print)	Orvill			Henr	У	K	EFAUVER	DEATH	1	1	- 28	1961
S. :	SEX	6 COLOR OR RACE	7. MARE	IED 🗌 NE	VER MARRIE	D X	8. DATE	OF BIRTH		9. AGE (In year: last birthday)			UNDER 24 HRS
_	male	white	WIDOWI	Basel Co.	DIVORCE			0-3-81		79 yr		00/5	TOOLS INCHI
10a	 JSUAL OCCUPATIO during most of work 	N (Give kind of work on ing life, even if retired)	lone 10b.	KIND OF E	BUSINESS O	RINDUS	TRY 11	BIRTHPLACE (Stole	or foreign	country)	12 C	IT ZEN OF W	HAT COUNTRY
_	Farmer, 1	horer		arm	?			Maryland				U.S.A.	
13	FATHER'S NAME						14 M	OTHER'S MAIDEN					
L	Oliver Kei							Martha_	Niki.				
		IN U. S. ARMED FOR If yes, give wor or dates of s		SOCIAL SE	CURITY NO.	. }7, IN	IFORMA	NT .		Ad	dress		
_	no		I.	foue		S	orin	gfield St	ate H	ospital	Recor	ds	
		TH [Enter only one co	use per lin	ne for (o), ((b), ond (c)	j						ONSET	AND DEATH
	PARI I. DEA	TH WAS CAUSED BY: IMMED: ATE CAUSE (o	Ce	rebra	1 thro	ombos	gis.					de	ys
	422.	/ DUE TO											
	Conditions, if an gave rise to in		Ar	<u>terio</u>	scler	otic	car	dio-vascu	ılar d	isease.		ye	ars
	cause (o), stating (
7	lying couse lost.) (c											
CATION	C.B.S. as	ersignificant con 1900. With 1900. With	cere	bral le br	arteri ain d	osc. isea	lero se.	sis, with with psyc	n psy.	reaction reaction	n?		WAS AUTOPSY PERFORMED? ES NO K
CERTIF	20a. ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY)	S JNDERLYING [] [] CAUSE OF DEATH MEDICAL EXAMINER)	20b. DES	CRIBE HOW	V INJURY O	CCURRED	D. (Enter	noture of injury in	Part I or Po	ort II of item 18)			
MEDICAL	20c TIME OF INJURY Hour o.m. p. m.	f Month, Doy, Yes	While at wor		while			NJURY (Home, far et, office bldg., et		ty or town)		(County)	(State
		t (I) (this haspital		led the d	deceased	fram that d	11 leath a	-14 19		1-28	, 19.	61, that	(I) (we) las tated abave

22a, SIGNATURE 22c PHYSICIAN'S NAME (Type)

230 BURIAL, CREMATION, REMOVAL (Speciff)

24 FUNERAL DIRECTOR'S SIGNATURE

Gladde, M.D. Raymond 23b DATE THEREOF

ADDRESS

22d. ADDRESS Sykesville, Maryland

MED DIRECTOR

23c NAME OF CEMETERY OR CREMATORY 23d LQCATION (City towh, or county)

25b. REGISTRAR'S SIGNATURE

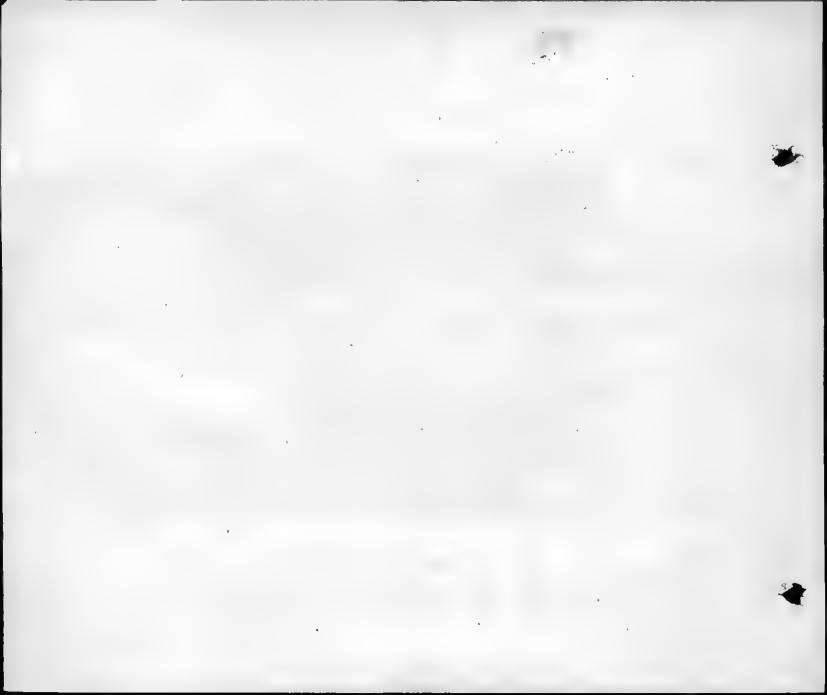
250. REC'D BY REGISTRAR DATE JAN 3 1 '61

Orthung S. Kraus

226 DATE S GNED -28-61

(State)

VR A1S (4) 15M 9/59



Mage 4

VR A15 (4)

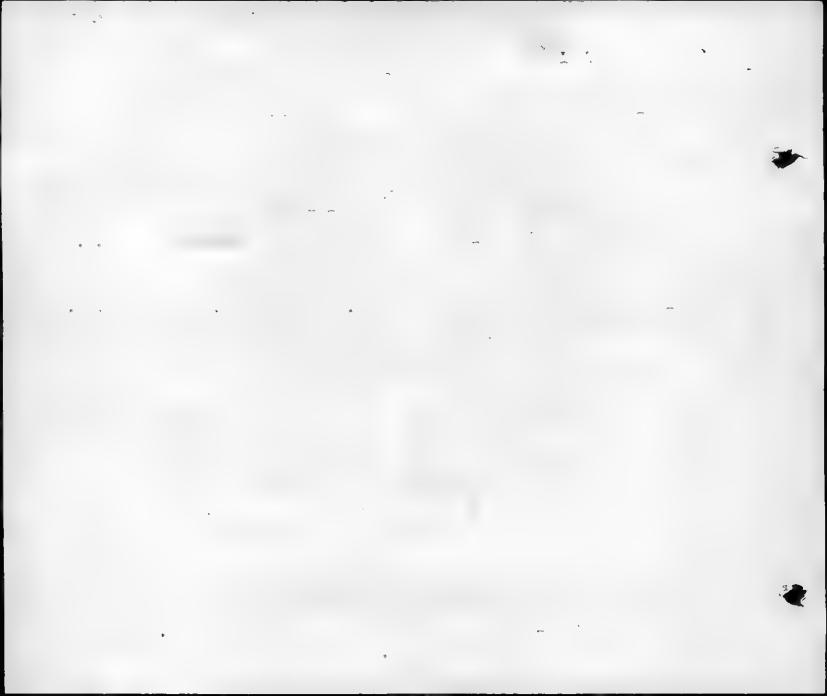
lows

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

	455)	CERTIFICA	ATE OF DE	ATH			61	453
PLACE OF DEATH COUNTY	Carroll		MARYLANG:	o. STATE	ence (Whe	re deceased lived.	If institution, Res. COUNTY		ámission)
rural S	ykesville		Life	1	_	tside corporate lim Svkesvi		ond give nearest	town)
d. NAME OF HOSPI OR INSTITUTION	TAL (If not in hospital, g	ive street	oddress)	d. STREET AD					RESIDENCE IN A FARM? S NO
3 NAME OF DECEASED (Type or print)	GEOR(ANTHONY	KING		4. DATE OF DEATH	JANUAF	RY 24,	Year 19 6 1
s. sex male	color or RACE	7 MARR	RIED NEVER MARRIED X	11-5-	1960	9. AGI lost	(In years IF JA birthdoy) Mon	ths Pays Ho	INDER 24 HR
100 USJAL OCCUPATE during most of wor NON (13. FATHER'S NAME	king life, even if refired	done 10b.	KIND OF BUSINESS OR INDU	JSTRY 11 BIRTHPLAN Ma 14. MOTHER'S A	ryla	nd Carro		U.S.	
15 WAS DECEASED EVE (Yes, no, or unknown)	UNKNO* R IN U. S ARMED FOR (If yes, give wer or dates of s	CES? 16.	SOCIAL SECURITY NO. 17, 8	Ad	<u>elin</u>	e Ison	Address		
gove rise to i couse (a), stating lying couse last. PART IF OTI	the under- DUE TO)	CONTRIBUTING TO DEATH BU	T NOT RELATED TO T	THE TERMIN	IAL DISEASE CONI	DITION GIVEN IN	P	ERFORMED?
OR CONTRIBUTING	AS UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER)	20b. DES	CRIBE HOW INJURY OCCURR	ED. (Enter noture of	injury in Po	ort I or Port II of i	tem 18.)	YE	б∏ ио[
ZOC TIME OF INJUING HOUR O. m., p. m	RY Month, Doy, Yes	20d U While of wor	Not while fo	LACE OF INJURY IN- octory, street, office I	ome, farm, bldg , etc.)	20f (City or tow	n)	(County)	(Stot
21 I certify the saw the decea 220 SIGNATURE	1111) attend -7 +	ded the deceased from.		at 6:4		auses and on		
22c PHYS CIAN'S NAME (Type) 23a BURIAL, CREMATIC	DN, 23b DATE THEREO		23c. NAME OF CEMETERY	22d. ADDRES	E 9	2:7 2 36 /-	A 7/2	Amm	Slee!
BURIAL	1-26-1		Fairvi			Carrol	L CO.	Marvla	
24 FUNERAL DIRECTOR	Waltz,	W	infield, Md.		250 REC'D	BY REGISTRAR N 2 7 61	256 REGISTRAR	S S GNATURE	

DATE



6.0454

L		436		CEKII	FICA	IE OF DEATH	l			11 U Jal 4	JI
1	PLACE OF DEATH					2. USUAL RESIDENCE (W	here deceases	d lived If institution	on Residenc	e before od m	nission)
/	Carroll			MAI	RYLAND	Maryland			Ifor		
	b. CITY OR TOWN (If RURAL and give nea		ts, write	LENGTH OF STA	Y IN 16	c. CITY OR TOWN (IF	outside corpo			ive nearest to	wn}
L	Sykesville			9 day	s	X Finksburg	R.1				
ſ	d. NAME OF HOSPITA OR INSTITUTION			ldress)		d. STREET ADDRESS				ON	ESIDENCE A FARM?
L	Springfield	State Ho	spital							YES	□ NO ☑
3	NAME OF DECEASED	Fir		Midd	le	Lost	4. DATE OF	Mon	lh	Day	Year
L	(Type or print)		ert Ra			Lambert	DEATH	Janue		25	1%]
1,	SEX	6. COLOR OR RACE	MARRIE	D NEVER MAR		3. DAJE OF BIRTH		9. AGE (In years lost birthday)	1	YEAR IF UN	
Ļ	Male	White	WIDOWED			10-3-82		78 yrs.			
1	during most of working	g life, even if retired	done 10b. KI)	ND OF BUSINESS	OR INDUS	TRY 11. BIRTHPLACE (Stole	e or foreign o	ountry)	12.CITIZ	EN OF WHA	T COUNTRY?
L		we trel		-		Maryland				U.S.A.	
1	3. FATHER'S NAME					14. MOTHER'S MAIDEN	NAME				
	John Lamb					Emily					
1	5. WAS DECEASED EVER	IN U. S. ARMED FOR yes, give wor or dates of s	CES? 16. SC	OCIAL SECURITY N	O. 17, IN	FORMANT		Add	ess		
	unknown	-		_	S	oringfield St	tate H	ospital			
Г	18. CAUSE OF DEAT	H [Enter only one co	use per line	for (o), (b), and (c				*		INTERVAL	BETWEEN
l	PART I. DEATI	H WAS CAUSED BY:	4 4			Heart Disease				ONSET AN	
l	4120	MMEDIATE CAUSE (o		GLTOSCIA	UGIU.	leart Disease	- :			yes	rs
	1200										
	Conditions, if on gove rise to im	mediate	*	onary Ar	ter10	sclerosis				yea	T.
	couse (o), stoting th										
١.	lying couse loss) (c				pneumonia					4 day
C a Ti Oak	PART II. OTHE	R SIGNIFICANT CON	DITIONS CO	NTRIBUTING TO D	EATH BUT	NOT RELATED TO THE TERM	INAL DISEAS	E CONDITION GIV	EN IN PART	1(o) 19. WA PER	S AUTOPSY FORMED?
		isted wit	h_arte	rioscler	osis					YES	NO 🗌
212020	20d ACCIDENT WAS OR CONTRIBUTING [(IF EITHER, NOTIFY N	JNDERLYING DEATH CAUSE OF DEATH LEDICAL EXAMINER)	20b. DESCR	IBE HOW INJURY	OCCURRED	(Enter noture of injury in	Port I or Por	t 11 of item 18.)			
1000	20c TIME OF INJURY	Month, Doy, Yes	ar 20d. INJ	URY OCCURRED	20e PLA	CE OF INJURY (Home, fare	m, 20f. (City	or town)	(C	ounty)	(Stote)
1001	Hour o.m.	19	While	Not while	foc	ory, street, office bldg., el	c.)		,	*,	
2	p. m		at work [ot work		<u> </u>	1				
	21 I certify that	(I) (this haspital		d the decease	d fram	1-16	261o_	1-25-	, 1951	, that (I)	(we) last
	saw the decease	d alive an	1-25-	1961 , an	d that d	eath accurred at 3	KM, fram	the causes an	d an the	date state	ed abave.
	220. SIGNATURE	P	D	4//	/	ATTENDING	450	CT + Cr			22b, DATE SIGNED
	N.	lachun	The state	Mad	U 1		AED DIRECTOR [STAFF PHYS 1	1-2	5-61	3.01420
	22c. PHYSICIANS/ NAME (Type)	1			-0	22d. ADDRESS					
		Raymond Gl.	adue.	M.D.		Springfield	d State	e Hospita	ıl, Sy	kesvil	le, Md
2	3a BURIAL, CREMATION			23c NAME OF CE	METERY O	CREMATORY	23d LOCA	TION (City, town,	or county)	(\$	fote)
	Sound Mark	1/28	161	Irrenti	2. 1	enotion	Ruga	1 mail	hna-	1.10	mi
2	FUNERAL DIRECTOR'S	SIGNATURE	11)	ADDRESS	0.0	Mo. REC	D BY REGIST	TRAR 25b, REGI	STRAR'S S G	NATURE	, Man
	J. 6. 1/1	sers/	1. [1]	sumu	SKO	DATE	IAN 9 7	10.4	Whomas &		
Ľ	y la . ! !	7 77		-		DATE	JAN Z	01	in dutional in	1. I brouder	

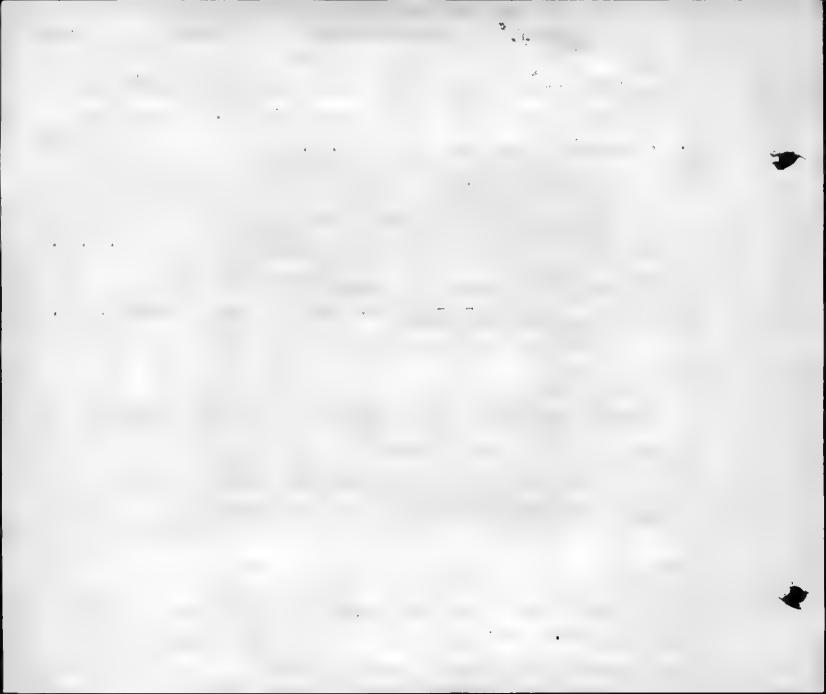
TO HOSP OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 th, its ofter death. Page 4 may be refained by the hospital or ottending physicion

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physicion and completely filled A.Aby the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or remarkal, and in any event, without 72 hours after death VR A15 (4) 15M 9/S9



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

necessary, please exe-tar. Page 4 should be

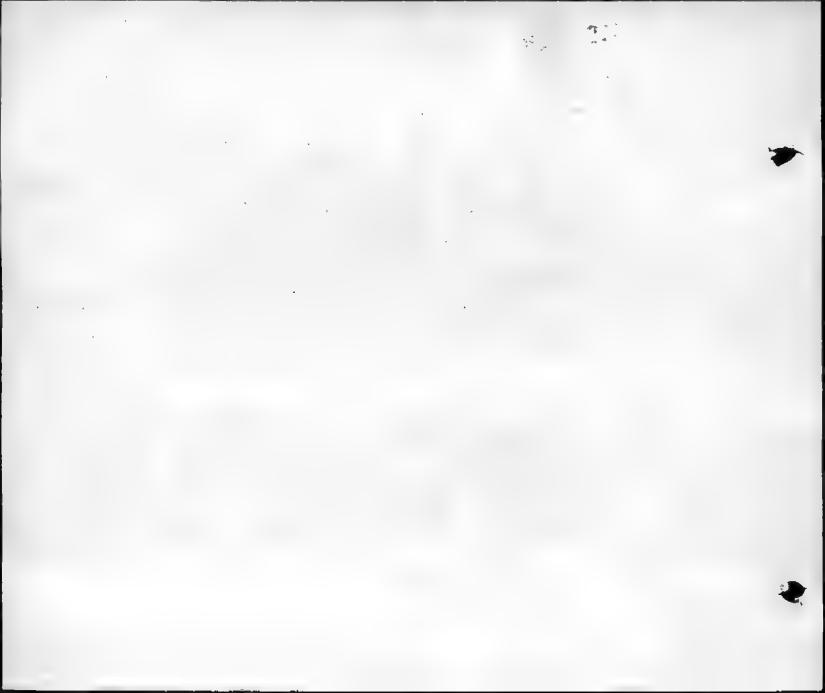


VS A1S (4) 1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 458

CERTIFICATE OF DEATH

						114 9: 01	31. 110.
1,	o. COUNTY	ef	MARYLEMO	2. USUAL RESIDENCE (W. o. STATE		If institution Resident	eller
	b. CITY OR TOWN (If outside corporate RURAL and give/neorest town)		TH OF STAY IN 16	c. CITY OR TOWN (IF	1 25		give nearest town)
	Westerna		-41	" / Wel	leur	isles	
	OR INSTITUTION 74 W.	del give street address	M	d. STREET ADDRESS	wille	au de	o. IS RESIDENCE ON A FARM YES NO
3.	NAME OF	First	Middle .	Last	4. DATE	2 Month	Day Year
	DECEASED (Type or print) A MI	E-V	- 40	ATS	OF DEATH	Jun	6 196
S.	SEX A 6. COLOR OR R	ACE 7. MARRIED NE	DIVORCED [B. DATE OF BIRTH	976 9. AGI	birthdoy) Months	Doys Hours Min
10a	. USUAL OCCUPATION (Give kind of w	ork done 10b. KIND OF	BUSINESS OR INDU	TRY 11. BIRTHPLACE (Stote	or foreign country)	12.CIT	ZEN OF WHAT COUNT
	during most of working life, even it re	hired)	-uk	7116	uf Con	ca	WBA
13.	FATHER'S NAME			14. MOTHER'S MAIDEN	NAME 7	-7	
15	WAS DECEASED EVER IN U S. ARMED	FORCES IL SOCIAL SE	CURITY NO	NFORMANT	102.2.2	Address	
[Ye	s. no or unknown) If yes, give wor or date		-1264	5 - Wholfer	uet LR	ine Wes	thursty I
	18 CAUSE OF DEATH [Enter only or		(b), and (c).]	J	*		INTERVAL BETWEEN
	PART I. DEATH WAS CAUSED IMMEDIATE CAUSED	BY: SE (o)	miti	on			MONT
		E TO A			1 -1.	^	
	Conditions, if any, which)	a Cenodi	wase	la accid	ent Ika	calmer.	lyear
	gove rise to immediate	(b) (b) (c) (d) (d) (d) (d) (d) (d) (d) (d) (d) (d			- 1	0	1
	lying couse lost,	(c)					
z	PART II. OTHER'S GNIFICANT		ING TO DEATH BUT	NOT RELATED TO THE TERA	LINAL DISEASE CON	DITION GIVEN IN PAR	T I(o) 19. WAS AUTOP
ICATION	Di	abole m	illetus				PERFORMED?
CERTIF	20g. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING [] CAUSE OF DE [IF EITHER, NOTIFY MEDICAL EXAMIN	ATH	V INJURY OCCURRE	 (Enter nature of injury in 	Part or Part of i	tem 18)	
MEDICAL	20c. TIME OF INJURY Month, Doy, Hour o. m.	Year 20d. INJURY OC		ACE OF INJURY (Home, for		(n) (r	County) (Sto
ME	p. m.	19 While Not of work of we	WILLIA				
	21. I certify that I attended	the deceased fram	Direct	Q , 1960, ta ;	for Go	, 1961, that I lo	ist saw the deceas
	alive on	12.6/,	and that death	occurred at 11:15	M, fram the c		e date stated aba
	ACTUAL Suliu	chapke		M.D. 856W.	200-11	ty or rown, store)	1/7/6
	PHYSICIAN'S NAME (Type)	us Chep	ko	Wester	unude-	nes	
220	BURIAL CREMATION, 226. DATE THE REMOVAL (Specify)	EREOF 22c. NAI	ME OF CEMETERY O	R CREMATORY	22d. LOCATION (C	City, town, or county)) Mal
23	FUNERAL DIRECTOR'S SIGNATURE	Ani ADD	RESS	24a. REC	D BY REGISTRAR	24b REGISTRAR'S ST	GNATURE
	DELLE 102/1/20	u Haru	polerel	MILA DATELA	N 1 0 '61	aritus S.	Kraeck



rs ofter death. Page 4

ATI	þ	010	de
ö	-mined	DIRECTO	d be
	5301		should
HOSP	be	FUNERAL	C)
유	тау ре	2	page
10	_	2	-
VR 15	A'	0/0	(4)

	300					•			
1. PLACE OF DEAT	Н				USUAL RESIDENCE (V	Vhere deceased li	red If institution	i: Residence	before admission)
C	arroll		MARYLAN	D	Maryland		D. COO!!!!		
	'N (If outside corporate limit we nearest town)	ls, write c	LENGTH OF STAY IN 1	ь	c. CITY OR TOWN (IF	outside corporate	e limits, write RU	RAL ond give	nearest town)
	vkesville		2 mos12 da	LYS.	Baltimore	#18		$\rightarrow V$	1
d NAME OF HO	SP TAL (If not in hospito, g	ive street od	dress)		d. STREET ADDRESS			- , -	a. IS RESIDENCE ON A FARM?
5 S	oringfield St	ate Ho	ospital	1	1528 Home		t.		YES NO
3 NAME OF DECEASED	Fire	st	Middle		Last	4. DATE OF	Month		Day Year
(Type or print)	Jame	9	Frank		LOWERY	DEATH	1	_	27. 1961
S SEX	6. COLOR OR RACE	7. MARRIE	NEVER MARRIED	□ B. D#	ATE OF BIRTH	9.		Months Do	
male	white	WIDOWED	DIVORCED [1 6	-5-79		81 7/1	MOULTS DE	gys Hours Min
10a USUAL OCCUI	ATION (Give kind of work of working life, even if retired)	done 10b KII	ND OF BUSINESS OR IN	IDUSTRY	11 BIRTHPLACE (Stot	te or foreign coun	iry}	12. CITIZE	N OF WHAT COUNTRY
Boat B					Maryland			U.	S.A.
13 FATHER'S NAME				14	. MOTHER'S MAIDEN	NAME			
James	Lowerv				Alice Con	rington			
	EVER IN U. S. ARMED FOR	CES? 16. SC	CIAL SECURITY NO. 1	7. INFOR			Addre	51	
no	ir yes, give war ar adies or s	Si vice;		Spri	ngfield St	tate Hos	nital Re	cords	
	DEATH (Enter only one co	use per line	for (a), (b), and (c).]	-					INTERVAL BETWEEN
1 1	DEATH WAS CAUSED BY:			ım on i					ONSET AND DEATH
147	IMMEDIATE CAUSE (o		aterial pneu	WIOII.	.8				uayo
Conditions				la ha	ant diane	an arith	oongosti.	770	
	o immediate DUE TO		erioscleroti	re He	BIL UISES		failure.		-
couse (o), sto	ring the under-		malimad ami		air.ar.f.a.		rarraro.		TOOMS
<u> </u>	OTHER SIGNIFICANT CON		eralized art				ONDITION CIVE	NI INI PART I	years
₽ FARITE									PERFORMED?
S C.B.S	. assoc. with							l.e.	YES NO
OR CONTRIBU	F WAS JNDERLYING FING CAUSE OF DEATH TIFY MEDICAL EXAMINER)	20b. DESCR	IBE HOW INJURY OCCU	RRED (Er	iter noture of injury ii	n Part I or Part II	of item 18.)		
	JJJRY Month, Doy, Yes	or 20d. INJ	URY OCCURRED 20e	. PLACE (OF INJURY (Home, for	rm, 20f. (City or	town)	{Co.	unity) (State
Hour o	m. m.	White of work (Not while	toctory,	street, office bldg., e	HC.}			
,	that (I) (this hospital			11	1-15-60 1	0 4. 1	-27-61	10	, that (I) (we) las
		-27-	19_ 61 , and the	اسطاحت (۱۱) افسماک ف		30 p.m.	Faul Wolfe,		for stated show
22o. SIGNATUI		1 2	17_Qas / Grid Tik	ai dean	r decorred of the	g ivi, (FCBII) III	e causes and	dit the c	22b. DATE
0.	aistina e	Vol!	Campa	M.D	ATTENDING	MED.	STAFF PHYS. TT		1-27-61
22c PHYSICIAL	is		C	741.0	22d. ADDRESS	DIRECTOR [THE LA		1-27-01
NAME (T	Agustin del	Camp	o. M.D.		Sykesyi	lle, Mar	vland		
23o, BUR AL, CREM			23c NAME OF CEMETER	Y OR CP	de		N (City, town, or	County)	[Stote)
Burial (Spe		1	Ft Lincol				r Manor	,,	(3,019)
24 FUNERAL DIREC			ADDRESS			C'D BY REGISTRA		TRAR'S SIGN	IATURE
	ch's Sons Hy	attev				EB 2 '61		Ing & 1	
4 4444101	Will Hij				DAIL				



	•	OF STATISTICAL RESEAR	CH AND RECORDS — BAC	IMORE 1, MA	-		
	460	CERTIFIC	CATE OF DEATH	1			60458
1. PLACE OF DEATH	arroll	MARYLA	2. USUAL RESIDENCE (V D. STATE Mary.		ed (f institution b COUNTY		hington
b. CITY OR TOWN (S RURAL and give no Sykesvil		25yrs.10mos		outside corporote rstown	i timits, write RU	RAL and give :	nearest town)
OR INSTITUTION	rat (If not in hospital, give seld State Hos		d STREET ADDRESS		210	3-1	e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF DECEASED (Type or print)	First Harry	Middle Elmer	Lucas	4. DATE OF DEATH	Month Janu		Doy Year 5. 1961
s sex Male		MARRIED NEVER MARRIED	-				AR IF UNDER 24 HRS 5 Hours Min.
	ON (Give kind of work dane king life, even if retired)	106 KIND OF BUSINESS OR	INDUSTRY 11 BIRTHPLACE (Stor	_	try)	12.CITIZEN	• A •
James A.	Lucas		14 MOTHER'S MAIDEN Susie Re				
	R IN U. S. ARMED FORCES' If yes, give wor or dates of service		Springfield	Hospita.	Addre 1 Record		
	TH WAS CALLED BY	per line for (o), (b), and (c).] Carcinoma of r	ectum with meta	istasis t	o brain	0	Months.
Conditions, if a gove rise to i couse (o), stoting lying cause last.	the under-						
3			TH BUT NOT RELATED TO THE TER			N IN PART 1(o	PERFORMED?
	AS UNDERLYING COME CAUSE OF DEATH MEDICAL EXAMINER)	DESCRIBE HOW INJURY OCC	CURRED (Enter nature of injury i	n Port I or Part II	of stem 18.)		
Y 20c. TIME OF INJUI		20d INJURY OCCURRED 2 While Not while of work	Oe. PLACE OF INJURY (Home, fa factory, street, office bldg., e		town)	(Caun	ly) (State

■y the attending physician an ampletely filled it. Then please remave carban papers. Pages 1 al, and in any event, within 72 hours after death. ATTENDING EMYSICIAN; The law requires that the death certificate Te exacuted within 24 page 3 should be detached far use as the burial-transit permit. the State Board of Health priar to burial, cremation, or remaval, may be V. S. ned by the hospital ar attending physician.

TO IUNERAL DIRECTOR: After this certificate has been signed

cremation, or remayal,

p. m.

220 SIGNATURE

200 PHYSICIAN S NAME (Type)

REMOVAL (Specify)

24 FUNERAL DIRECTOR'S SIGNATURE

Burial

saw the deceased alive an

230 BURIAL, CREMATION, 236 DATE THEREOF

21 I certify that (I) (this haspital) attended the deceased from 3/7/55

Agustin delCampo,

the funeral director, should be filed with filed with

urs ofter death. Page

VR A15 (4) 1SM 9/59

22d. ADDRESS Springfield Hospital, Sykesville, Md.

M D

ATTENDING PHYS

STAFF PHYS MED.

_____, to Jan.

61 and that death accurred a 2:10 M from the causes and on the date stated above

. 12.

/5/61ED

(State)

22b DATE

19.61. that (1) (we) last

(State)

23c NAME OF CEMETERY OR CREMATORY U. Cemetery

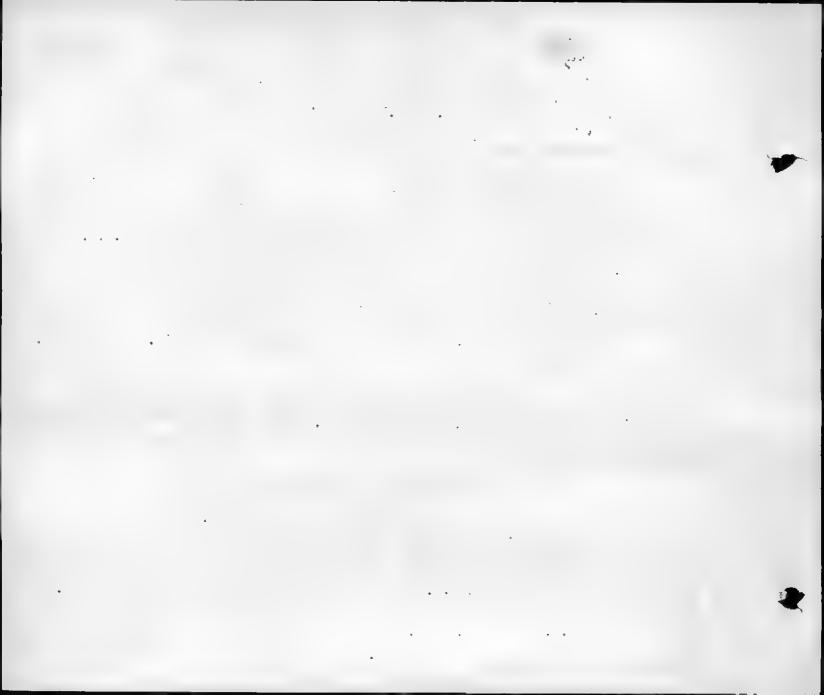
ADDRESS

Home: Sykesville, Md.

23d LOCATION (City, town, or county) Shenandoah, Virginia

2So. REC'D BY REGISTRAR DATELN 9

256 REG STRAR'S SIGNATURE



I director, filed with after death. funeral 200 filled er death papers. 퓽 gud carban physical remove B ā 6 permit gned burial-transit

TO FUNERAL VR A15 (4)

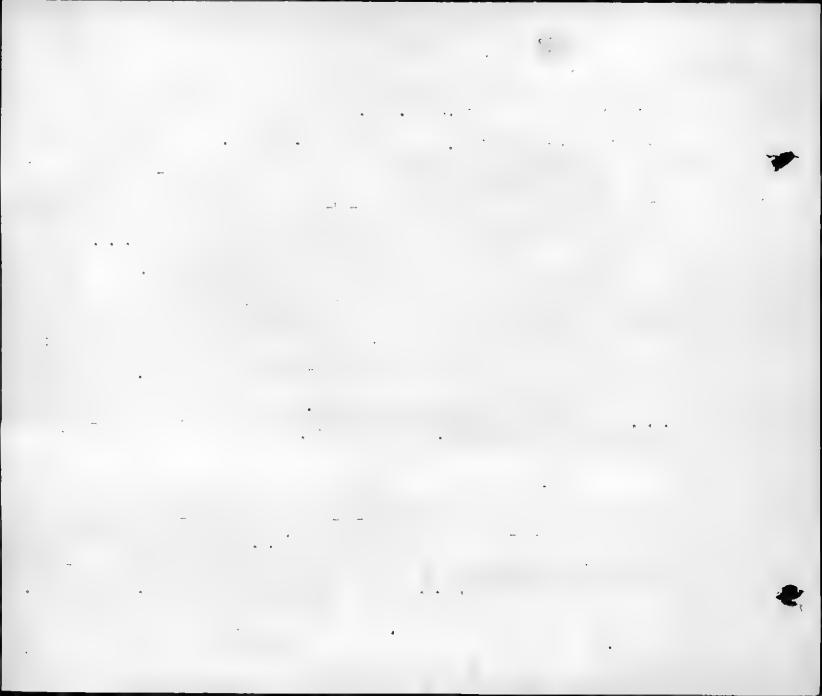
certificate

DIRECTOR;

should

es

許 ō



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1. MARYLAND 60460CERTIFICATE OF DEATH eral director, be filed with Poge PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased livid, If institution-fee dence before admission) a. COUNTY b. COUNTY dryols MARYLAND CITY OR TOWN (If purside corporate limits write RURAL analytive neglect town) funeral E LENGTH OF STAY IN 16 outside corporate limits, write RURAL and give nearest town) e IS RESIDENC YES NO DATE OF DEATH Middle DECEASED death. (Type or print) 9. AGE (In years lost birthday) 5. SEX 6 COLOR OR RACE B DATE OF BIRTH IF UNDER TYEAR IF UNDER 24 HRS MARRIED NEVER MARRIED completely Months Days Haurs after WIDOWED | DIVORCED papers. 100 LSUA/OCCUPATION (Give kind of order dane 10b. KIND OF BUSINESS OR INDUSTRY during most of mosking life, even refired) 12. CIZIZEN OF WHAT COUNTRY? Carre and ban I 13. FATHER'S/NAMI physician remaye 17 INFORMANI 15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. attending please 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: á permit gned gove rise to immediate DUE TO couse (o), stoling the underbeen si lying couse ost. **burial-transit** TOT 19 WAS AUTOPSY cremation, PERFORMED? YES NO I 200 ACCIDENT WAS INDERLYING OR CONTRIBUTING IT CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Bart I ar Part II of item 18) certificate 20c TIME OF INJURY 20e PLACE OF INJURY (Home, form, 20f (City or town) Doy, Year 20d. INJURY OCCURRED (County) factory, street, office bidg., etc.) Hour a m. White Not while of work of work

After this DIRECTOR: þ Baard (should TO FUNERAL c

REMOVAL (Specify)

22a SIGNATURI

22c. PHYSICIAN'S

NAME (Type)

Konstantin 23g BURIAL CREMATION, 23b DATE THEREOF

21 I certify that (1) (this haspital) attended the deceased fram

SONS

M.D. 23c. NAME OF CEMETERY OR CREMATORY

Oak Street. Sykesville, Maryland

STAFF PHYS

23d LOCATION (City, town, or county) BALTIMORE NATIONAL CEM BALTIMORE

and that death occurred at o

M D

ATTENDING

22d. ADDRESS

24 FUNERAL DIRECTOR'S S GNATURE SANDER &

saw the deceased alive an

ADDRESS BALTO. INC.

25a REC'D BY REGISTRAR DAMAN 1 8 '61

M.

MED DIRECTOR

25b. REGISTRAR'S SIGNATURE Caroling & Know

from the causes and an the date stated above

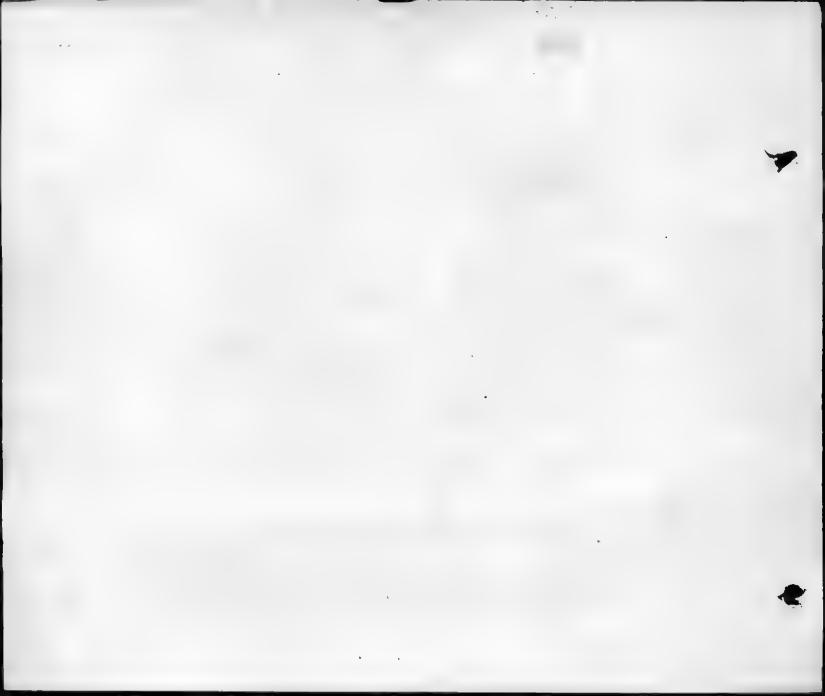
Year

19

(State)

22b DATE SGNED

(State)



SIGNED Springfield State Hospital 3 should 230 BURIAL, CREMATION, 236 DATE THEREOF 23c NAME OF CEMETERY OF CREMATORY 23d LOCATION (City, fown, or county) (Stote) page the Sta REMOVAL (Specify) 4NNUNCIATION 0 25. REGISTRAR'S SIGNATURE 24 MUNERAL DIRECTOR'S SIGNATURE ADDRESS. 250, REC'D BY REGISTRAR lour DATE ISM 9/59

. IS RESIDENCE

Hours

12. CITIZEN OF WHAT COUNTRY?

Sykesville, Md.

Days

Years

Years

1961 that (N (we) last

(County)

PERFORMED?

YES NO

(Stote)

22b DATE

INTERVAL BETWEEN

ONSET AND DEATH

U.S.A.

Months

Doys

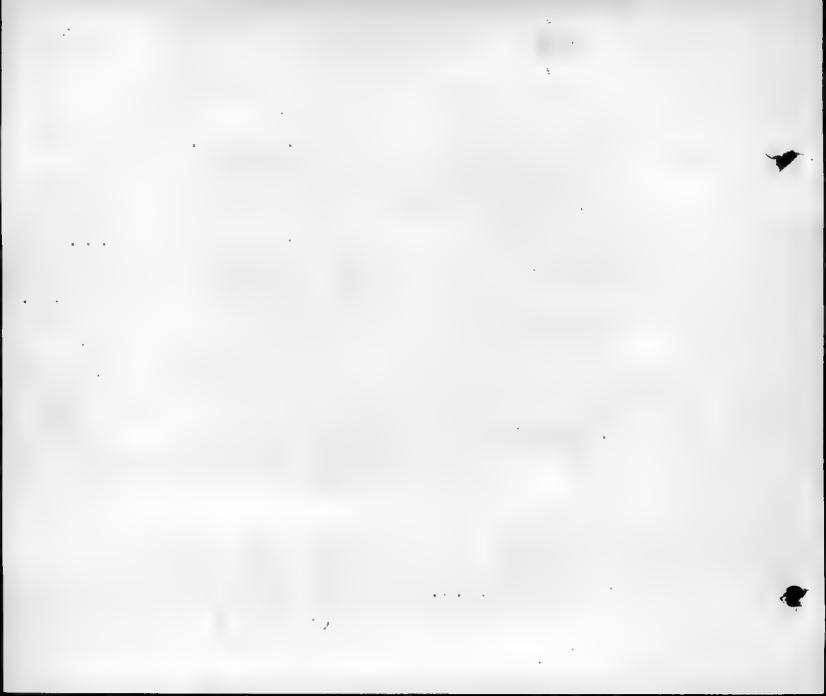
ON A FARM?

YES NO

Yeor

1961

FUNERAL DIRECTOR:



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 464

60462

PLACE OF DEATH O. COUNTY			2.	USUAL RESIDENCE (WE o. STATE			Residence bei	fare admissio	hu)
Carroll		MARY	LAND	Maryland		COUNTY	神色学		/
	f autside carparate limits, write arest lawn)		.	c. CITY OR TOWN (IF	outside carporate lin	mits, write RURA	At and give n	earest town)	ð
Sykesvil		Byrs.5mos.	26de sE			4 200	V		
OR INSTITUTION	AL (If not in haspital, give stree	_		d. STREET ADDRESS				e IS RESIG	FARM?
Springfi	<u>eld State H os</u>	pital	111.8	04_Guilford	Avenue			YES 🔲	NO NE
3 NAME OF DECEASED	First	Middle		Last	4. DATE OF DEATH	Month	-	/	ear
(Type ar print)	Elizabe			Morton	1	January			<u>%1</u>
5. SEX	6 COLOR OR RACE 7. MA	RRIED 🔲 NEVER MARRIE		DATE OF BIRTH	9. AG		UNDER 1 YEA	1	Min Min
Female	WILLE	VED DIVORCED	_A	9-15-69		91, yrs.			
100. USUAL OCCUPATIO during mast af wark	ON (Give kind af wark dane 10th ling life, even if retired)	. KIND OF BUSINESS OF	R INDUSTRY	11 BIRTHPLACE (State	ar foreign country)		12. CITIZEN		DUNTRY?
Waitress			-	German			unk	nown	
13. FATHER'S NAME			1	4. MOTHER'S MAIDEN I	NAME				
Peter M	11100			Rarhara	Ommart				
15. WAS DECEASED EVE	R IN U. S. ARMED FORCES? 11	S. SOCIAL SECURITY NO	17, INFO		I_OMBIALL O	Address	Sykes	277177	0
No No	If yes, give war or dates of service)	_		pringfield	State Ho.	snital_	Man) A T T T C	3
		15 2 2 3 4 5 1 2 3 3	.1	bringing	B 44 4 110			yland	
	TH [Enter only one cause per	line far (a), (b), and (c).						NSET AND	
FART I. DEA	TH WAS CAUSED BY: IMMEDIATE CAUSE (a) CO	ngestive Hea	art Fa	ilure				l week	
1 st d	DUE TO	0							
Canditions, if a	ny, which is the first	teriosclerot	in Co	ndi ove soule	m Dieane			vear	
gave rise to it	mmediate (Ler Tusc Terror	JLC US	TUTOVASCULA	I DISCASE			- year	
tying cause last.	the under-	ipheral vasc		indufficion	or with	re m come m		mont	he
	IER SIGNIFICANT CONDITIONS	h							
CBS assoc	. with circula	tory distur	bance	, with cere	bral arte	rioscle	roŝis,	PERFOR YES []	SWED5
OR CONTRIBUTING	LI CAUSE OF DEATH I	SCRIBE HOW INJURY OF	CCURRED. (Enter nature of injury in	Part 1 or Part II of	item 18)			
	MEDICAL EXAMINER)	_							
20c, TIME OF INJUR		INJURY OCCURRED		OF INJURY (Hame form y, street, affice bldg., etc		wn)	(Count	у)	(State)
D. m.	19 Whi	e Natwhile ark at wark		_	1	_			
	it (1) (this haspital) atter	adad the deceased	fram	8-5 - 19	57 . ta	1- 31-	10 61	that /1) /u	va) last
saw the deceas		31 19.61 pand							
22a SIGNATURE	/\	7 / 010	mai dea	ill discorred dr1_	JING HORN INC.	cooses ond	dii iic da		DATE
	1. Roynes	nd Stade	U M.O	ATTENDING M	IED STA	AFF YS DX		1/31/	SIGNED 61
22c PHYSICIAN'S				22d. ADDRESS					
NAME (Type)	J. Raymond G.	ladue, M.D.		Springfie	ld Hospit	al, Syl	cesvil]	Le, Md	•
23a BUR AL, CREMATIO	N, 236 DATE THEREOF	23c NAME OF CEMI	ETERY OR C	REMATORY	23d LOCATION	City, tawn, ar o	caunty)	(State))
Removal (Specify)	Feb3,196					rson,	. '		
24 FUNERAL DIRECTOR	S SIGNATURE	ADDRESS	45	25a. REG	D BY REGISTRAR	256 REGISTR	AR'S SIGNAT	URE .	
The & th	tenes 60	2901-14	AXI	DATE F	ÉB 6 '61'	am	五十元		

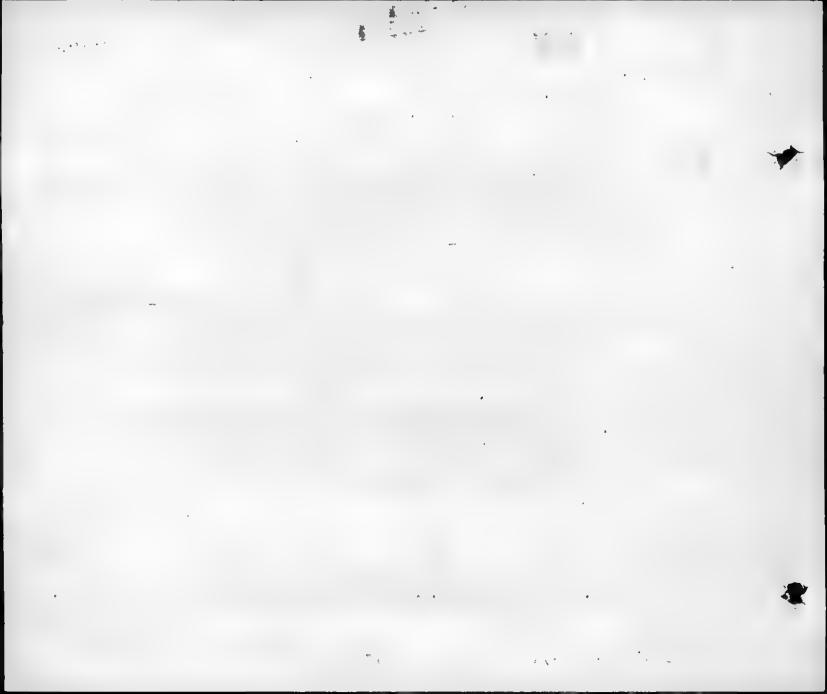
TO HOSP OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 21 havins after death. Page 4 may be Quined by the hasp toll ar attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and camptetely filled to by the funeral director, page 3 shauld be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or remaval, and in any event within 72 hours ofter death. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 28 had

14 X

urs after death Page 4

VR A15 (4) 15M 9/59



10 HOS

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
65 CERTIFICATE OF DEATH

465

PLACE OF DEATH O. COUNTY Carre	.11		MARY	LAND	2. USUAL RESIDENCE		d lived If institut b. COUNTY			mission)
	(if autside carporate limi	ts, write	c. LENGTH OF STAY	IN 16	Maryls		prate limits, write l	Carro RURAL and g		ławn)
	niontown		Lifetime		Rural	Union	town			
d. NAME OF HOSE OR INSTITUTION	PITAL (If not in hospital, g	jive street	address)		d. STREET ADDRESS				01	RESIDENCE N A FARM?
3. NAME OF	Fir	st	Middle	-	Last	4. DATE	Ma	nth	Day	Year
(Type or print)	Marsh	ahl			Myers	OF DEATH	January	7].		1966
5. SEX	6. COLOR OR RACE	7. MARR	IED KNEVER MARRIE	DI	B DATE OF BIRTH		9. AGE (In years	IF UNDER	YEAR IF U	NDER 24 HRS
Male	White	WIDOW			February 13	3. 1881	last birthday) 70 yrs	Months	Doys Ha	urs Min.
10a. USUAL OCCUPAT	ION (Give kind of work)	done 10b.		R INDUS				12. CITIZ	EN OF WHA	AT COUNTRY
Farmer	orking life, even if retired		wn Farm		Carroll	Co M	amel and	17	S.A.	
13. FATHER'S NAME			WII Palm		14. MOTHER'S MAIDE	N NAME	ar A Tand	1 0,	O H.	
Tomic	Marana				353	and Man				
Lewis	MYETS FER IN U. S. ARMED FOR	CES2 14	SOCIAL SECURITY NO.	17 IN	WILSOU	uri Nusl		iress		
(Yas, no, or unknown)	(If yes, give wor or dates of a		••							_
No.	EATH [Enter anly one co		None	Wig	rs. Marshall	Myers	R#5 Wes	tmins		arylar
	EATH WAS CAUSED BY: IMMEDIATE CAUSE (o)	acut	ie.	My Cary	lid p	rdi	tis	ONSET A	ND DEATH
gave rise to couse (a), statin lying cause las	g the under- DUE TO									
PART II. O	THER SIGNIFICANT CON	-	CONTRIBUTING TO DEA	TH BUT	NOT RELATED TO THE TE	RMINAL DISEA	E CONDITION GI	VEN IN PART	PE	AS AUTOPSY ERFORMED?
20% ACCIDENT V OR CONTRIBUTION (IF EITHER, NOTIF	VAS UNDERLYING DATH G CAUSE OF DEATH FY MEDICAL EXAMINER	20b DES	CRIBE HOW INJURY OF	CCURRE	D. (Enter nature of injury	in Part I or Pa	rt II af item 18)			
Y 20c TIME OF INJU	10	or 20d II While of wor	NJURY OCCURRED Nat while at work		ACE OF INJURY (Home, fatory, street, affice bldg.,		y or tawn)	(C	aunty)	(Stote
	nat (I) (this haspital) attend				1260 10	- T			
22a SIGNATURE	ased alive an	1-1	LE 19 England	that d	leath accurred at	14M, trop	the causes a	nd an the	date sta	22b DATE
I I SIONATORE	2/1	1	Lega	- 1	M D. ATTENDING	MED DIRECTOR	STAFF PHYS			SIGNE
22c PHYSICIAN'S NAME (Type)	- T H.	LE	66		22d ADDRESS	111.	er J	nin	31	mo
23g BUR AL, CREMAT REMOVAL (Specif Burial	(y)	961	23c NAME OF CEME				TION (City, town,		11	(State)
		701	ADDRESS	O CIII		EC'D BY REGIS	TRAR 256 REG	ISTRAR'S SIG	NATURE	
24 FUNPTAL DIRECTO		Tro.	nesstown Me	Mar 7	DATE!	JAN 5	:1 .	where of		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

COAGA

25b. REGISTRAR'S SIGNATURE

Children S. Kraus

25a. REC'D BY REGISTRAR

DATEJAN 1 9 '61

	D14 191014	W.	STATISTICAL RESEARCH ATTO	NE-COND.	A DATE
4					
~			CEDTIEICATI	COET	JE A TL
. 3	6		CERTIFICATE		
•	340				

					1 1 1 1
PLACE OF DEATH o. COUNTY Carroll	MARYLAND	2. USUAL RESIDENCE (Who o. STATE Unknown	ere deceased lived. If ins b. COL		fore admission)
b. CITY OR TOWN (If outside corporate limits, v RURAL and give nearest town)	1		utside corporate limits, w	rite RURAL and give n	earest town)
ral) Sykesville, d. NAME OF HOSPITAL (If not in hospitol, give or Institution	street oddress)	d. STREET ADDRESS	*		e. IS RESIDENCE ON A FARM?
Springfield State	Hospital	1		unkno	TIMES NO
NAME OF First DECEASED (Type or print) Abra	Middle aham	Paymer	4. DATE OF DEATH	Month I	Day Year L7 19 61
	MARRIED NEVER MARRIED 🖾	B. DATE OF BIRTH	9 AGE (In y		R IF UNDER 24 HR
mala shita	DIVORCED	8-14-1887	last birthd	yrs Months Doys	Hours Min
Da USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	106 KIND OF BUSINESS OR INDU	STRY 11 BIRTHPLACE (Stote	or foreign country)	12. CITIZEN	OF WHAT COUNTRY
Factory work		Germany		German	ly
FATHER'S NAME		14. MOTHER'S MAIDEN N	AME		•
Meyer Paymer		Annie Hir	rsch		
5. WAS DECEASED EVER IN U. S. ARMED FORCES Yes, Ind. or unknown) [If yes, give wor or dates of service		NFORMANT	1.	Address	
unknown	none	Hospital Reco	ras		
1B CAUSE OF DEATH [Enter only one cause		• _ •		10	ITERVAL BETWEEN NSET AND DEATH
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (o)	Cardiac insuffi	rcrency		<u> </u>	minutes
TAR DUE TO	Canana 14 3	1 1			, .
Conditions, if ony, which) (b)	Generalized art	teriosclerosis		L	yrs.plus
gove rise to immediate Couse (o), stating the under-					
lying couse lost. (c)					
Schizophrenic reacti	*****	NOT RELATED TO THE TERMI	NAL DISEASE CONDITION	N GIVEN IN PART 1(0)	PERFORMED?
		m er	hand have Board Harf Street 15	11	YES NO K
20g ACCIDENT WAS UNDERLYING (1) 20g OF CONTRIBUTING (1) CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	DESCRIBE HOW INJURY OCCURRE	D (Enter noture of injury in t	OLL I OLL LOUI II OLL II OMI 10	,	
Hour o.m		ACE OF INJURY (Home, form ctory, street, office bldg., etc.		(Count	y) (Stat
21. I certify that (I) (this haspital) a		. 10 שליים.	53 to Jan	76 .19 67.	that (I) (we) la
saw the deceased alive an Jan.					
220/ SIGNATURE MIZO	. 30	ATTENDING ME			226 DATE SIGNE
22c PHYSICIANS NAME (Type) Myron Nizank	kowsky, M.D	22d. ADDRESS	field State		
30 BURIAL CREMATION 236 DATE THEREOF	23c NAME OF CEMETERY C	OR CREMATORY	23d LOCATION (City, to	own, or county)	(Stote)
BURIAL Jan 18/61	Oheb Shalom		Baltimore,	Md.	

ADDRESS

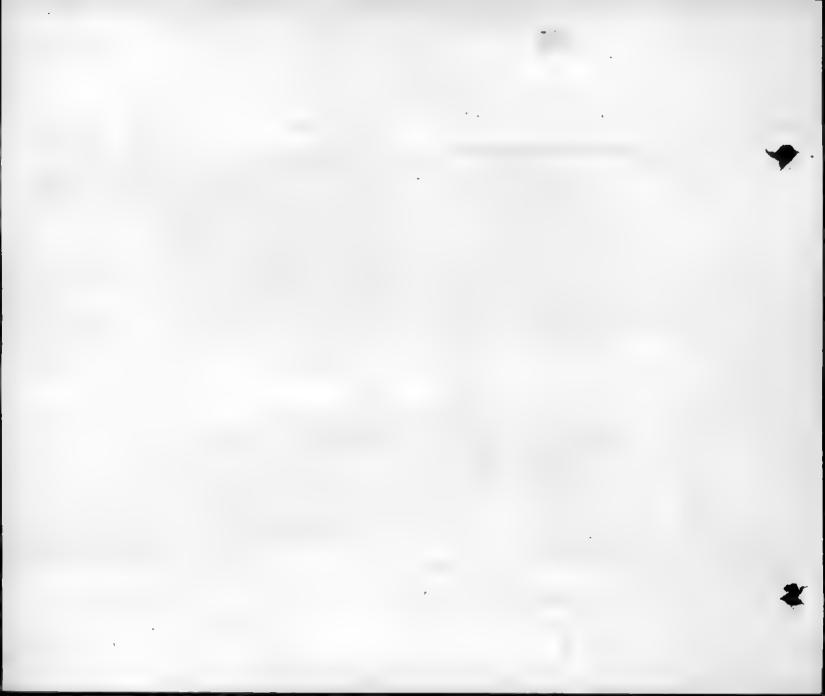
SOLLEVINSON " BROS. INC. BALTO. 15, MD.

y the funeral director, 12 should be filed with TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physician and completely filled page 3 shauld be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 the State Board of Health prior to burial, cremation, ar removal, and in any event, within 72 haurs after death. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 ned by the haspital or attending physician.

rs after death. Page 4

VR A15 (4) 15M 9/59

24 FUNERAL DIRECTOR'S SIGNATURE



TO HOS! COR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 the softer death. Page 4 may be recoved by the hospital or ottending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Roges 1 and 2 should be fitted with the registrar prior to burial, cremation, ar removal, and in any event within 72 haurs after death.

1	MARYLAND STATE	DEPARTME	NT OF HEALTH	-BALTIMORE, 1	8		
)	467	CERTIFICA	TE OF DEATH		Reg. Dist. No	0040	3:5
1	1. PLACE OF DEATH a. COUNTY TALL	MARYLAND	o. STATE 77 22 2		42221	1	n)
	b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town)	G G/22	c. CITY OR TOWN (IF 6)	tside carporate limits, write R	URAL and give ne	arest fawn)	
	d. NAME OF HOSP TAL (If not in hospital, give street address) OR INSTITUTION (A 2) (4)		d. STREET ADDRESS	rall ST	. 1	e. IS RESIDI	ARM?
	3. NAME OF DECEASED (Type or print) PNNIE REB.	M'ddle ECCA	PETRU	4. DATE OF DEATH JAN	1, 2,		61
	5 SEX/ 6. COLOR OR RACE 7 MARRIED NE	DIVORCED	Sept. 20, 12	9. AGE (In years last birthday)	Manths Days	Hours	Min,
	19a USUA. OCCUPATION (Give kind of work done of work done during most of working life, even if whited)	SUSINESS OR INDUST	Carrol	1Commend	12. CITIZEN O	5 G	UNTRY?
)	13 FATHER'S NAME FITTS		14. MOTHER'S MAIDEN NA	wintre	de		
	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes. no. or unknown) (If yes. give were or dates of Service)	- m	SOLA STACE	am Peter	y Sume	- add.	21.23
	18. CAUSE OF DEATH [Enter only one cause per line for (a), (PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Darl	tro-enteril	is !		TERVAL BETV ISET AND D	
	Canditians, if any, which gave rise to immediate (b)	ius in	fortion			inves	te.
	cause (a), slating the <u>under:</u> DUE TO lying couse last. (c)			-			
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE Chronic Myelo	Jonon	~ Leut	ramia; H	perteur	PERFORA	NO TO
	GR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		(Enter nature of injury in Po		, , 		
	Zoc. TIME OF INJURY Manth, Day, Year 20d. INJURY OCC Haur a. m. While at wark at wark at wark	vhile facts	CE OF INJURY (Hame, form, ory, street, office bldg., etc.)	20f. (Cily ar town)	(County)	(State)
	21. I certify that I attended the deceased from alive on 28, 1961,		1950, to 9	A, from the couses an	that I lost said an the date		
	ACTUAL Sulius Chapter	0		DORESS (Street, city or lawn,	state)	DATE	SIGNED
	PHYSICIAN'S Julius Chepi	ko	Urtu	unter Nes	٨	1291	61
	BANKAY 1/3/6172	AE OF CEMETERY OR	march.	ALMIL Si	Y House	·(State)	N
	23 JUNERAL DIRECTOR'S SIGNATURE ADDITION OF THE PROPERTY OF TH	ress	MA DATE FEE		ethur S. Kra		



4	7	Æ	!!	-
Page	lirecto	\ <u>₹</u>		1
ath	eral o	F A	1	
ar de	Fun.	400	* . /	_
S affi	y the	2 C	15	
3	5	Buo		3.
n 24	filled	ges 1		L
with	stely	er de		S.
pain	ample C	spers rs af		100
exec	o pu	on po		
le be	o ubi			13.
ifica	hysic	0 3 T	1 /	10. 13.
h cer	5	ever	-	[71
deat	thend	plea n any		
t the	th = 0	Then and is		
s tha	yd E	nt.		
quire	due	rema		
W re	men s	ransil n, or		Z
he la	Phys d sol	rial-tr	Campanan	MEDICAL CERTIFICATION
L Ä	oding cafe I	e bu	* ************************************	ERTIF
SICIA	ertif	as th		CALC
PHY.	al ar this c	ta b		MEDI
NG.	fter i	ed for		
TEND	the h	stach ealth	7	
R AT	d by	be de	1	
Ö	L DIR	oard		
SP	be -	3 sh		23
H	FUN	be St		(
TO HOSP OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 how is after death. Page 4	may be V.C. ned by the haspital ar attending physician TO FUNERAL DIRECTOR: After this certificate lias billen signed by the attending physician and campletely filled by the funeral director.	page 3 shauld be detached for use as the burial-transit permit. Then please remove about papers. Pages 1 and 2 shauld-berkled with the State Board of Health priar to burial, crematian, or remaval, and in any eventy within Rhours after death	0	23
15/	ATS M 9/5	9	101	L

	200								., .	90
1	PLACE OF DEATH o. COUNTY				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before add o STATE b. COUNTY					
_	Carroll		MARYL		Mary	land		Ment	gomer	<i>y</i>
	 CITY OR TOWN (If autside corporate limit RURAL and give nearest town) 	ts, write c. L	ENGTH OF STAY II	ИЪ	c CITY OR TOWN (If o	utside carporate (ii	mils, write RI	JRAL and give	e nearest tow	n)
	Sykesville	5у	rs.9mos.2	210本	rs Germa	ntown R#	1			
	d NAME OF HOSPITAL (If not in hospital, g OR INSTITUTION	ive street addre	233)		d. STREET ADDRESS		10	-	e. IS RE	SIDENCE A FARM?
	Springfield State	Hospita	1		None					NO [4
3.	NAME OF Fire	si	Middle		Last	4. DATE	Mon	th	Day	Year
	(Type or print) Mill.	ard	Alonz	30	Reid	OF DEATH	Jaı	mary	7.	1951
S.	SEX 6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	8	DATE OF BIRTH	9 AC	E (In years	IF UNDER 1 Y		
	Male White	WIDOWED		_	February 13		t birthday)	Months Do	iys Hours	Min
10	USUAL OCCUPATION (Give kind of work of during most of working life, even if retired)	dane 10b. KIND	OF BUSINESS OR	INDUST		4	C	12 CITIZEI	NOF WHAT	COUNTRY?
	Carpenter	,	_		Hansas			1.	S.A.	
13	. FATHER'S NAME				14. MOTHER'S MAIDEN N	IAME			AN ARE	
	John Reid				Lottie Ku	rns				
15	. WAS DECEASED EVER IN U. S. ARMED FOR	CES? 16. SOCI	IAL SECURITY NO.	17, INF	ORMANT		Adde	ess		
ĘŦ	(If yes, give war or dates of si	Buates)	-		Springfield	Hospital	Recor	rds.		
	18. CAUSE OF DEATH [Enter only one co	use per line fa	(a), (b), and (c).]						INTERVAL B	ETWEEN
	PART I. DEATH WAS CAUSED BY:	Arte	riosclero	otic	cardiovascul	ar disea	se		Year	rs
	1 + 2 3. B DUE TO									
	Conditions, if ony, which)	A								
	gave rise to immediate									
	lying cause last.									
Z		DITIONS CONT	RIBUTING TO DEAT	TH BUJ N	OT RELATED TO THE TERMI	NAL D SEASE CON	IDIŢION GIV	EN IN PART 1	(a) 19 WAS	AUTOPSY
CATION	C.B.S. assoc. with ci	rc.dist	with ce	rehi	ral arterioso	clerosis	withou	ıt		ORMED?
CERTIF	OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
CAL	20c TIME OF INJURY Month, Doy, Yes	or 20d. INJUR	Y OCCURRED 2		E OF INJURY (Home, form		wr)	(Cou	inty)	(Stole)
MEDICAL	Hour o.m	While of work	Not while at work	racto	ory, street, office bldg., etc.	1				
~	21. I certify that (I) (this haspital				3/16/55 19	, to Jan	7	30 67	46-4-615	forma N. Amora
	saw the deceased alive an 1/	7 /6 1	19 and 1	that de	ath accurred at 9 = 3		-		* '	
	220 SIGNATURE		/ dila	death accurred at 9:30PNam the causes and an the date stated above						
	11-17 1111. b.				M.D ATTENDING MED STAFF 1/8/51					
	62c PHYS CHANS	7-	1		22d. ADDRESS					- 100
	NAME/lype) Agustin de	1Campo.	M.D.		Sprin fi	eld Mosp	ital,	Sykesv	ille,	Md.
23	A BURIAL CREMATION 236 DATE THEREC)F 725	HAME OF COME	ERY OR	CHEMOTORY O	23d LOCATION	C ly, lown,	or county)	n (Sta	ate)
1	REMOVA] (Spec fy) 1-12-6	1/1/	John.	Ma	d. Idroof	Salt	inc	J. Dr	led.	
24	FUNERAL DIRECTOR'S SIGNATURE		ADDRESS			D BY REGISTRAR		STRAR'S SIGN	ATURE	
	tom V H Herry	4	14/15	, 8	DATE DATE	H Z 0 '61	C.,	Thomas de "		



469 CERTIFICATE OF DEATH

60467

	403		OLICIII IO		OI BEAIN				00200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			MARYLAND		USUAL RESIDENCE (WHO STATE Mary)			Residence talto.	
			S. 8mos. 10		c. CITY OR TOWN (IF o		nits, write RURA	AL and give	nearest town)
	L (if not in haspital, give	street address)			d. STREET ADDRESS	alther Bl	vd.	- No.	IS RESIDENCE ON A FARM? YES NO 2
3. NAME OF DECEASED (Type or print)	First W ini f		Middle Elizabe	eth	Root	4. DATE OF DEATH	Month Janu	ary	Doy Year 15, 1961
5. SEX Female	6 COLOR OR RACE 7 White wi	MARRIED N	NEVER MARRIED _	8. D	August 23,	7.006 last		UNDER 1 YI	EAR IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work dane 10b. KIND (during most of working life, even if refired)			BUSINESS OR INC	DUSTRY	11. BIRTHPLACE (Stoke Maryland		NOFWHATCOUNTRY		
13. FATHER'S NAME James Mc	Mahon			14	Mother's Maiden N	Strasbur	g		
1S WAS DECEASED EVER (Yes, no. or usknown) (H	IN U.S. ARMED FORCES: yes give war or dates of service			INFOR	mant ingfield Ho	ospital R	ecords		
PART I DEAT		Bronch	lopneumoni		bilateral ardiovascul	ar disea	se		interval Between onset and Death 1 week Years
Cause (a), stating It lying cause last. Page II. 07HE Psychosis	RS CHIFICANT CONDITUENTS WITH SYPHIL							IN PART 1((a) 19 WAS AUTOPS PERFORMED? YESPE NO
	AEDICAL EXAMINER)				nter nature of injury in				
20c. TIME OF INJURY Hour u.m. p.m.	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED Hour a.m. 19 While Not while at work at work at work 19 While Not work 19 While								
	21. 1 certify that (I) (this haspital) attended the deceased fram. May 5,, 1951, ta 1= 15= , 1961, that (I) (we) lass sow the deceased alive an 1=15 = 1961, and that death accurred at 114M, fram the causes and an the date stated above 220 SIGNATORE ATTENDING PHYS DIRECTOR DIRECTOR 11/15/61								
22c PHYSIQIAN'S NAME (Type)	J. Raymond				Springfie				
2 of BUR AL, CREMATION REMOVAL (Specify)	1-19-196	./ //	ORELL	OR CR	L PARK	23d LOCATION (270	1	(State)
24 (FUNERAL DIRECTOR'S	SIGNATURE	130 JA	DRESS /	1	250. REC'	D BY REGISTRAR	25b REGISTR		

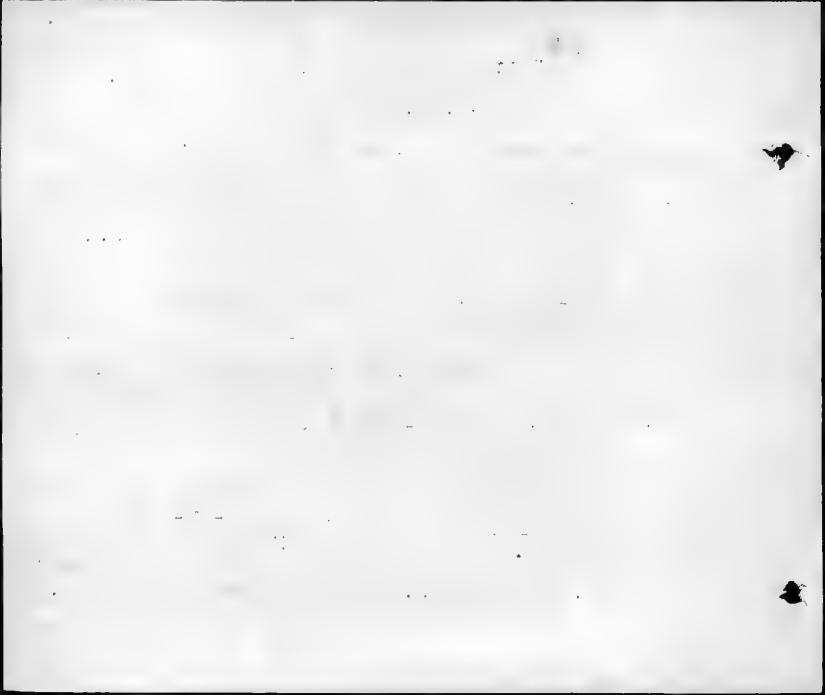
TO HOSP COR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hamony be V. ned by the hospital or attending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled poge 3 should be detached for use as the burial transit permit. Then please remote carbon papers. Pages 1 or the State Board of Health prior to burial, cremation, or removal, and in our exemption 72 hours after death.

VR A15 (4) 15M 9/59

rs ofter death Page 4

y the funeral director, 2 should be filled with



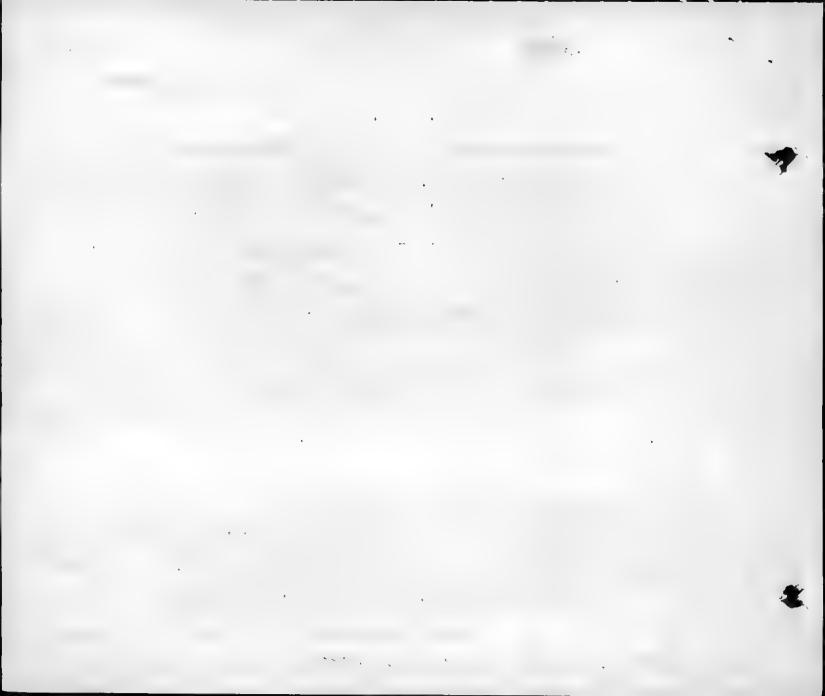
VR A1S (4) 1SM 9/S9

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

470

60468

- 1								-						
	1. PLACE OF DEATH d. COUNTY Carroll				2.	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b COUNTY								
				MARYL	AND	Maryland County went								
		CITY OR TOWN (if outside corporale limits, write RURAL and give nearest lawn)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest/town)								
	Sykesville 27 yrs5 mos			nos	den an	<u>thesda</u>		1 - X						
	d NAME OF HOSPITAL (If nat in hospital, give street address) OR INSTITUTION				d. STREET ADDRES	SS			e. IS RE	SIDENCE A FARM?				
- [Spring	gfield Stat	e Hos	pital		77	am_Road		YES	NO 🔀				
	3. NAME OF DECEASED	Fire	st	Middle		Losi	4. DATE OF	Mor	ith	Day	Year			
	(Type or print)	Matt		м.		SCHNETDER	ATH 1 -		28 1961					
-1	S SEX	6 COLOR OR RACE	7. MARRI	ED NEVER MARRIED	B C	ATE OF BIRTH		9. AGE (In years last birthday)	Months Do		1			
	female	white	WIDOWE	Sep Sep	[28]	10-19-84		76 yrs	would Do	ys Hours	POID.			
	10a USUAL OCCUPATIO	ON (Give kind of work of king life, even if retired)	dane 10b. I	KIND OF BUSINESS OR	INDUSTRY	11 BIRTHPLACE (S	State or foreign	country)	12 CITIZEN	OF WHAT	COUNTRY?			
	Housewi		'		-	Pennsy	lvania		U.S.A.					
	13. FATHER'S NAME				1	4. MOTHER'S MAID	EN NAME							
1	Henry A.	Gripp			[Isabel.	la Weir							
4	15. WAS DECEASED EVE			SOCIAL SECURITY NO.	17, INFO			Add	ress					
	no	(it yes, give wor or oches of s	acvace;	None	Spr	ingfield_	Hospita	l Records						
	18. CAUSE OF DEATH Enter only one couse per line for (o), (b); and (c).] INTERVAL BETW													
	PART I, DEATH WAS CAUSED BY BIZER +. Then monia ONSET AND DEATH TOLE													
	LL/L × DUE TO													
	Conditions, if any, which) in Chronic conjective heart failure													
	gove rise to immediate DUE TO													
	Conditions, if any, which gave rise to immediate couse (a), stating the under-tying couse last. DUE TO Ryon matic heart divease years													
	PART II. OTH	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(of 19 WAS AUTOPSY PERFORMED? Schizophrenic reaction, other and unspecified.												
,	Schizophrenic reaction, other and unspecified.													
	200. ACC DENT WAS UNDERLYING I 20b DESCRIBE HOW INJURY OCCURRED. (Enter notice of injury in Port I or Port I or frem 18.)													
		MEDICAL EXAMINER)												
	ZOC TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or lown) (County) (SI									(Stote)				
	20c TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED Hour a. m. While Nat while p.m. 19 at work at work													
	21 certify the	at (1) (this hasnital) attend	ed the deceased f	ram 9	-11	1933to	1-28	1961	that (I)	(we) lost			
	,					th accurred of	20 a. m							
										2b. DATE				
	Class	olm de	1 (1	mbo	M.D	M.D. ATTENDING MED STAFF M.D. PHYS DIRECTOR PHYS X 1-28-61								
	22c PHYSICIAN'S			1		22d. ADDRESS								
	NAME/(Type)	Agustin de	el Car	npo, M.D.		Sykesv	ille, M	aryland						
	23a. BURIAL, CREMATIC	N, 23b. DATE THEREC)F	23c. NAME OF CEMET	ERY OR C	REMATORY	23d LOC	ATION (City, town,	or county)	(S1c	rte)			
Burial 2/1/61 Rockville Cemetery Rockvill								e Mar	me fur	d				
	24, FUNERAL DIRECTOR	S SIGNATURE		ADDRESS	الياستان		REC'D BY REGI		STRAR'S SIGN.					
	Reder A	Bumbhre	EN E	ethesas.	Mar	V LACOT DATE	EFFR 2 '	61	TI 11 8 15	Ratio				
				and the second s	A W SY U L	- 40. 9	7 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1							



1. PLACE OF DEATH-USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a COUNTY b COUNTY MARYLAND . c. CITY OR JOWN (If autside corporate limits, write RURAL and give nearest tawn) b CITY OR TOWN (if autside carporate limits, write c. LENGTH OF STAY IN 16 RURAL and give nearest Jown) nuce d NAME OF HOSPITAL (If nat in haspital, give street address) d. STREET ADDRESS . IS RESIDENCE OR INSTITUTION ON A FARM? YES NO F NAME OF First Middle 4. DATE OF Month Day Year DECEASED (Type ar print) DEATH 19 S SEX 6 COLOR OR RACE 9 AGE (In years light birthday) IF UNDER 1 YEAR! IF UNDER 24 HR 7. MARRIED NEVER MARRIED DATE Months Days Min. Hours DIVORCED WIDOWED 🗀 TT YES 10a. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) LC. S. A 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 17. INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 Address INTERVAL BETWEEN 1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). ONSET AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Canditians, if any, which (6) gave rise to immediate **DUE TO** cause (a), stating the underlying cause last, PART N. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? YES NO I 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, 20f. (City ar tawn) Day, Year (Caunty) (State) factory, street, affice bldg., etc.) Hour a m While Nat while at wark at wark p. m 21 | certify that (1) (this haspital) attended the deceased fram. that (I) (we) last saw the deceased alive an and that death accurred all 9 M. from the causes and an the date stated above 22a SIGNATURE 22b. DATE SIGNED ATTENDING PHYS STAFF PHYS. MD DIRECTOR -22c PHYSICIAN'S 22d. ADDRESS NAME (Type) M.C.Porterfield. 23b DATE THEREOF 23g. BURIAL, CREMATION. 23c NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State) REPLOVAL (Specify)

25b REGISTRAR'S SIGNATURE

Orthur S. Kraus

25a. REC'D BY REGISTRAR

DATE JAN 9

filed with the funeral c should be fil 70 filled death ages papers. cample and pou physician remove gvent aftending please Allo the þ permit has been signed **burial-transit** Ь crematian, detached FUNERAL DIRECTOR: þ ġ 3 shauld page the Sto 0

Page ,

death.

VR A15 (4) 1SM 9/59

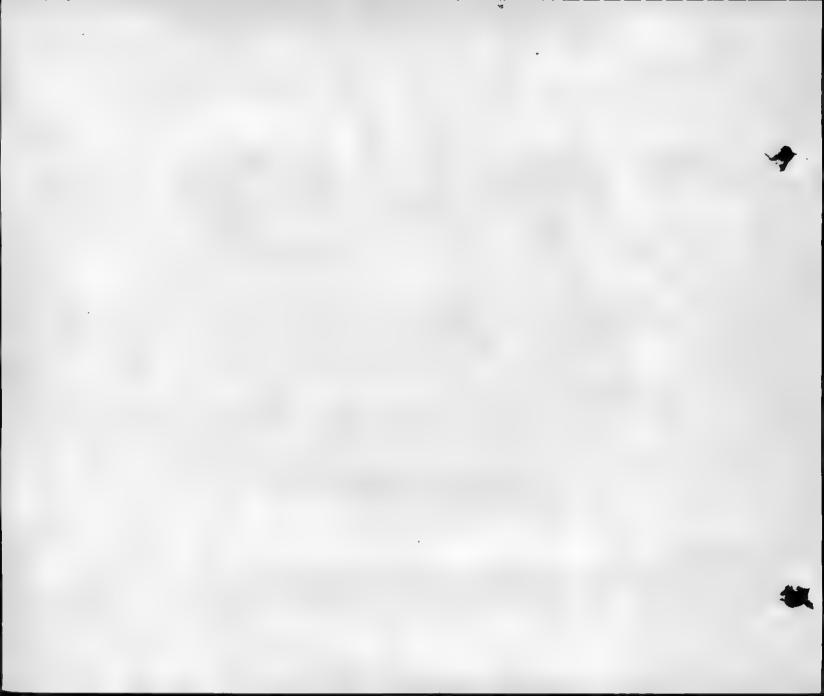
FUNERAL D RECTOR'S SIGNATUR



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 4 should be Reg. Dist. No. cremation PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission a. COUNTY **b.** COUNTY MARYLAND buriol, b. CITY OR TOWN IIf outside corporate limits, write RURAL c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) and give negrest levent d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO Z NAME OF Middle DATE Month Day Year DECEASED OF DEATH (Type or print) 19 6 S SEX 7. MARRIED ANEVER MARRIED 9. AGE (In years IFUNDER TYEAR IF UNDER 24 HRS. last birthday) Months Hours WIDOWED [7] DIVORCED | 10g. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State of foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME VD. S. ARMED FORCES? 15. WAS DECEASED EVER IN U. Address 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I, DEATH WAS CAUSED BY: men IMMEDIATE CAUSE (+) DUE TO Conditions, if any, which gave rise to immediate cause DUE TO (o), stoting the underlying cause last. Office PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY used as CATION PERFORMED? NO [YES 🗍 20g. EXTERNAL CAUSE WAS PRIMARY G or CONTRIBUTING G 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.) CAUSE OF DEATH. 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) foctory, street, office bldg., etc.) (Stote) (County) Hour Not while ø. m. al work ol work p. m. 21. I certify that I taak charge of the remains described above, held an Autapsy ... Inspection . Inquiry . and find that death resulted fram: Natural causes ... Accident . Suicide . Hamicide , Undetermined cause . DATE SIGNED ACTUAL CHIEF MEDICAL EXAMINER SIGNATURE ASSISTANT MEDICAL EXAMINER [T DEPUTY MEDICAL EXAMINER TO NAME (Type) ... 220. BURIAL, CREMATION, 226. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (State) REMOVAL (Specify) **ADDRESS** 23. FUNERAL DIRECTOR'S SIGNATURE 24b. REGISTRAR'S SIGNATURE 24a, REC'D BY REGISTRAR Chillian & Frank

DATERM

VS. ATSME(S) SM 9/SS



FOR STATE HEALTH DEPT.

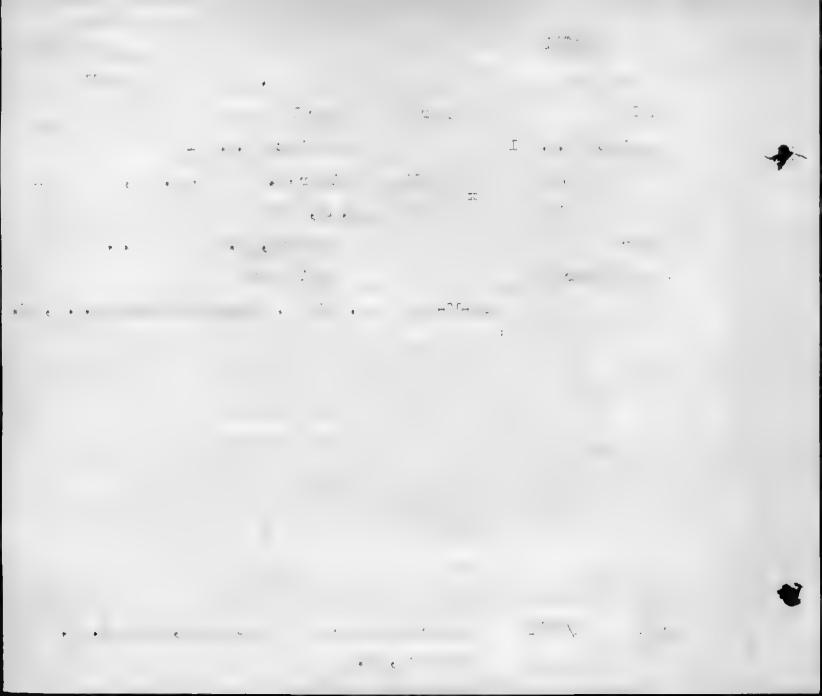
Heat TO DEP OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If A clay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Ronard director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM2 Rage 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event which 72 hours after death.

VS. A15ME 5M 7/S9

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

473 MEDICAL	EXAMINER'S CERTIFIC	CATE OF DEATH	60477
Rural	maryland c. Length of stay in 16 5 Yrs 8. State c. city or to	OWN (If outside corporete limits, write RURA	Carrell L and give nearest town
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospit Westminster R.D. # 1 3. NAME OF DECEASED (Type or print) S. SEX 6. COLOR OR RACE 7, MARRIED WIDOWED 10e. USUAL OCCUPATION (Give kind of work 110b, kin)	Midd e Last Franklin Steinour Never Married B. Date of BIRTH	Jr. PAGE (In years IF UN last birthdey) 1886 74	
done during most of working life, even if retired) Painter 13. FATHER'S NAME		burg, Pa	U.S.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yesgiva war or dates of service) 16. SC 18. CAUSE OF DEATH (Entar only one cause par line PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (e) DUE TO Conditions, if eny, which gave rise to immadiata causa (a), stelling the underlying Cause last. (c)	6-12-6375 Mrs. Emily	M. Steineur Westmin	ster R.D. 1, Md INTERVAL BETWEEN ONSET AND DEATH
PART I OTHER SIGNIFICANT CONDITIONS CONTI	RIBUTING TO DEATH BUT NOT RELATED TO THE		PART I(a) 19. WAS AUTOPSY PERFORMED? YES NO
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 21. I certify that I took charge of the remaindeath resulted from. Natural causes	Not While et work fectory, streat, office bleen work for streat above, held an Autopsy Accident , Suicide , Hom	dg., etc.)	(County) (State)
EXAMINER'S NAME (Pool REMOVAL (Spacify) ACTUAL SIGNATURE AME AME AME AME AME AME AME A	M.D. ASSISTAL	NT MEDICAL EXAMINER MEDICAL EXAMINER Street, city, town, or county) 22d. LOCATION (City, town, or co	DATE SIGNED 1/13/6/ (Stete)
Burial 1/17/61 23. FUGRAL DIRECTOR 23. FUGRAL DIRECTOR (1/17/61	0.443 B-	Gettysburg Ada: 15. REC'D BY REGISTRAR 24b. REGISTRAR ATE JAN 1 6 '61 Cothur	MS CO PO

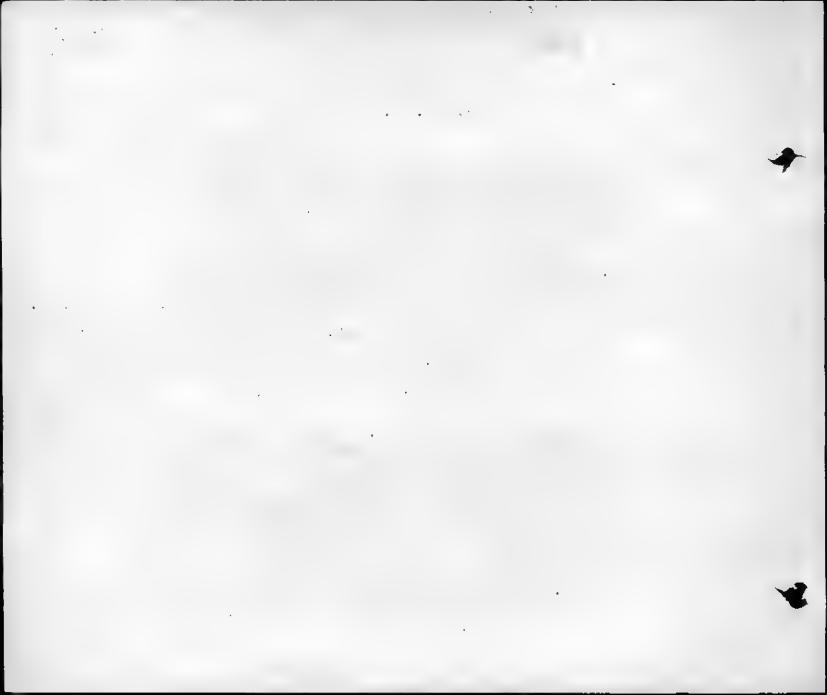


VR A15 (4) 15M 9/59

174

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

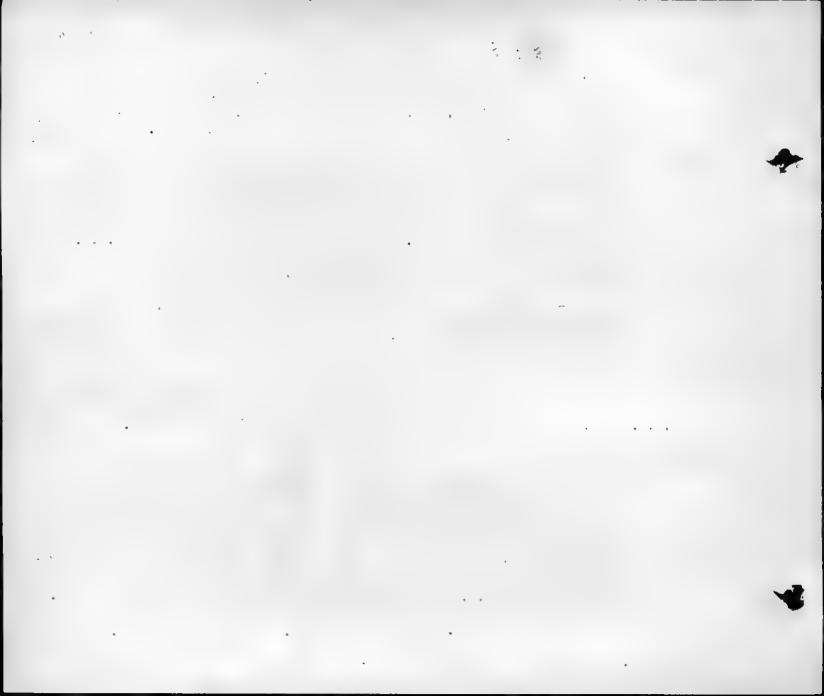
3	* 1										14/1
1. PLACE OF DEATH o. COUNTY Carroll			MAI	RYLAND		dence (who		lived. If instituti b. COUNTY		e befor	e ddmission)
b. CITY OR TOWN (If outside c		s, write c	LENGTH OF STA	Y IN 16				ate limits, write R	URAL ond gi	ve nea	rest town)
RuralSykesvil		in it	Ly. 12m.	112	Baltin			*	1 "	1	La
d NAME OF HOSPITAL (If not				chr.i.e	d STREET A				7		. IS RESIDENCE
Springfield Stat	te Hos	pital			2010 W	Valbro	ok Ave	nue			ON A FARM?
3 NAME OF DECEASED (Type or print)	Loret		Middl M	le av	Strone		4. DATE OF DEATH	Mor	nth	Day	Year 9 1961
				4/	DATE OF BIRT		DEATH	AGE (in years	IE UNDER 1		IF UNDER 24 HRS
		WIDOWED	NEVER MARE		8/21/0		,	lost birthdoy)		Doys	Hours Min
10a. USUAL OCCUPATION (Give k	ind of work d	ione 10b. KIN	ND OF BUSINESS	OR INDUST	RY 11 BIRTHPL	ACE (State 1	or foreign cou	inliny)	12 CITIZ	ENOF	WHAT COUNTRY?
during most of working life, en housework	ren if retired)		Home	12	Ma	arylan	d		U	SA	
13. FATHER'S NAME					14. MOTHER'S	MAIDEN N	IAME				
William M. McC	reevy				Ruppe	211					
15. WAS DECEASED EVER IN U. S. (Yes, no, or unknown)	ARMED FORG	CES? 16 SO	CIAL SECURITY N	O. 17 INF	ORMANT			Add	Iress		
no		4	nk-	Spr	ingfiel	ld Hos	pital	records	, Syke	svi	lle, Md.
18 CAUSE OF DEATH Enter					3314					INTE	RVAL BETWEEN
PART I. DEATH WAS C	'AUSED BY: TE CAUSE (0)	Rine	eumatic 1	yocar	CILDS					da	ys
111/	DUE TO	Sul	paortic S	Stenos	is					ve	ars
Conditions, if only, which			7401 010 1							30.	
cause (o), stating the under-	DUE TO	Uı	oper Res	pirato	ry Trac	t Inf	e rtio n			da	У
	ICANT CONE		TRIBUTING TO D	EATH BUT N	IOT RELATED TO	THE TERMII	NAL DISEASE	CONDITION GIV	VEN IN PART	1(0) 19	WAS AUTOPSY
Schizophrenic											PERFORMED? YES NO 🔀
200. ACCIDENT WAS UNDERLOW OR CONTRIBUTING CAUSE U (IF EITHER, NOTIFY MEDICAL	OF DEATH	206. DESCRI	BE HOW INJURY	OCCURRED	(Enter nature o	f injury in P	Part For Port	It of item 18)			
Y 20c. TIME OF INJURY Month, Hour a. m.	Day, Yea	While _	Not while		TE OF INSURY (I			ar town)	[C	aunty)	(State)
21 I certify that (X) (thi	s hasnital'	attended	the decease	d From	June 2	7 19	17 10	1/19/	1961	th	at (1) (we) last
saw the deceased alive		1/19/	/ 100			d of 11:	Ofram t				stated abave
220 SIGNATURE	1.	lla	hu.		ATTENDING	G ME	ED _	STAFF			225 DATE 1/19/6
22c PHYSICIAN'S		4		M	D PHYS 22d ADDRE		RECTOR [Id State	. U.an		
NAME (Type) Rita	S. Gla	ehn				PPI	_	e. Mary	- 14	T val	L
23a. BURIAL, CREMAT ON, 23b. I	ATE THEREO	F 2	3c, NAME OF CE	METERY OR	GREMATORY	/		ON (City, town,			(Stote)
REMOVAL (Specify)	27-	61	Theu-	(al	heat a		13a	Hiner	c.,	4	rd.
24 FUNERAL DIRECTOR'S SIGNAT	JRE _	16/20	AODRESS'	M	que!		D BY REGISTR		ISTRAR'S SIG		
Mullitary)	Yal H	11 6	Typelser	Lee,	ma.	DATE J	IN 3 0 '6	il c	Irilmy S.	tun	Ам



VR A15 (4) 15M 9/59

V

475 CERTIFICA	TE OF DEATH	
1. PLACE OF DEATH O COUNTY	2 USUAL RESIDENCE (Where deceased lived If institution: Residence a STATE COLINTY	before admission)
Carroll MARYLAND	Maryland Car	roll
b CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town)	c CITY OR TOWN (If autside corporate limits write RURAL and gir	re negrest town)
Sykesville 2yrs.6mos.28d		tal & lived
d NAME OF HOSPITA. (If nat in haspital, give street address) OR INSTITUTION	d. STREED CHET address unknown.	on a farm?
Springfield Hospital	\$	YES NO 📆
3 NAME OF First Middle DECEASED	Last 4. DATE Month	Day Year
(Type or print) Albert Richard	Swankhaus DEATH January	8, 1961
S. SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED	lost birthdov)	YEAR IF UNDER 24 HRS loys Hours Min.
Male White WIDOWED X DIVORCED	August 17, 1899 61 yrs Months	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		EN OF WHAT COUNTRY?
Senior clerk State of Md.		.S.A.
73 FATHER'S NAME	14 MOTHER'S MAIDEN NAME	
Michael Swankhaus 75. Was deceased ever in U. S. Armed Forces? 16. Social Security NO 117. (Lena Hite Swankhaus	
(Yas, no, or unknown) (If yes, give war or dates of service)		
	pringfield Hospital Records.	INTERVAL REVINCENT
1B. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c)] PART I, DEATH WAS CAUSED BY:		ONSET AND DEATH
IMMEDIATE CAUSE (6) LODAY Pholimonia	, left lung	1 day
DUE TO		
Conditions, if any, which (b)		
cause (a), stating the <u>under-</u> lying cause lost.		
/ [6]	IT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART	I(a) 19. WAS AUTOPSY
C.B.S. assoc. with cerebral arterioscle C.B.S. assoc. with cerebral arterioscle 20. Accident was underlying [] OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	erosis without qualifying phrase.	PERFORMED? YES K NO
206. ACCIDENT WAS UNDERLYING DESCRIBE HOW INJURY OCCURRING OR CONTRIBUTING CAUSE OF DEATH	ED (Enter nature of injury in Part I or Part II of Item 18.)	
OR CONTRIBUTING II CAUSE OF DEATH		
		unty) (State)
Hour o.m. While Not while to get wark of wark	octory, street, office bldg., etc.)	
21 I certify that (I) (this haspital) attended the deceased fram	June 10. 1058 mJanuary 8, 1061	that (I) (wa) last
	death accurred a PM M, from the causes and an the	
220 SONATURE / / / / /	deally occorred or agently from the cooses dita an inc	22b DATE
Coustin del Campo	M.D. PHYS DIRECTOR PHYS	1/9/81
22c PHVS CANS NAME (Type)	22d. ADDRESS	
Agustin del Campo, M.D.	Springfield Hospital, Sykesvi	lle, M _d .
230. BURIAL, CREMATION, 236 DATE THEREOF 23c NAME OF CEMETERY C	OR CREMATORY 23d. LOCATION (City, town, or county)	(State)
Burial 1-12-1961 SS.Peter &	& Paul Cem. Cumberland. Md.	
24, FUNERAL DIRECTOR'S SIGNATURE ADDRESS	25a. REC'D BY REGISTRAR 2S6 REGISTRAR'S SIG	NATURE
James F. Scarpelli, Cumberland, M	1d. DAJEAN 11'61 Calling & #C	



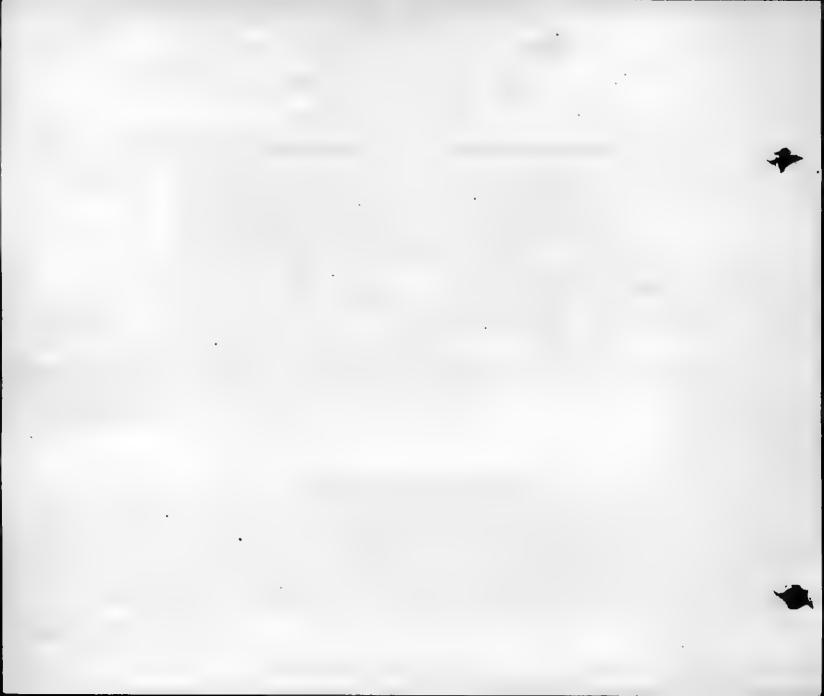
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND 7.0 CERTIFICATE OF DEATH

476

00474

		LACE OF DEATH	/		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
		Chronell	- 60-	MARYLAND	o. STATE Mary land COUNTY Carroll
	ŀ	CITY OR TOWN (If outside corpor	ote limits, write	LENGTH OF STAY IN 16	c. CITY OR TOWN (If outside corporate limits, write RURAL and give neares) town)
		RURAL and give maces towal		40 YRS	Release
,	(OF INSTITUTION	spitol, give street ad	dress)	d. STREET ADDRESS e. IS RESIDENCE ON A FARM?
,	6	Varmet	a RA	9#4	Westmuster ROTHY YES NO BY
	3. I	NAME OF	First	Middle	Lost 4 DATE Month Day Year
		Type or print)	9PD /	RANSY	TAYLOR DEATH Lan. 30 1961
	5 9	EX 6. COLOR OR	RACE 7. MARRIE	DEVER MARRIED	B DATE OF BIRTH 9 AGE (in years IF UNDER 1 YEAR IF UNDER 24 HRS ast birthday) Months Days Hours Min
		male who	WIDOWED	DIVORCED	March 30 1882 (Past birthdoy) Months Doys Hours Min
	10a	USUAL OCCUPATION (Give kind o	work done 10b. KI	NO OF BUSINESS OR INC	USTRY 11 BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?
		World Com	estra Ko	redo Wellet	Currell Co. md. U.S.a.
	13.	FATHER'S MAME	1.	7	14 MOTHER'S MAIDEN NAME
1		Weggh Jo	into		Ausm. Janlon
/	15 (Yes	WAS DECOUSED EVER IN U. S. ARM	ED ORCES? 16. SC	OCIAL SECURITY NO. 17	INFORMANT
		(11) 31. 31. 31.	-	1	up. H. K. Jandoz , Keese, Mrd.
		18. CAUSE OF DEATH [Enter only	one cause per line	for (a), (b), and (s)	INTERVAL BETWEEN ONSET AND DEATH
		PART I. DEATH WAS CAUS IMMEDIATE C	ED BY AUSE (a)	esetera	effenosshate ydays
		422.1	DUE TO	0	- 0 1-6.
		Conditions, if any, which	(b) DC	yestere	cion, & Cardie Obstular Sugar
		gave rise to immediate couse (a), stating the under-	DUE TO	10.	a final year
		lying couse last.	(c) 1C	leses	& aren selioses for
rs.	CERTIFICATION	PART II. OTHER SIGNIFICAN	NT CONDITIONS CO	INTRIBUTING TO DEATH B	UT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPSY PERFORMED?
J	SAI				YES NO NO
	RTIF	20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF	DEATH	IBE HOW INJURY OCCUR	RED. (Enter noture of injury in Part I or Port II of item 18)
		(IF EITHER, NOTIFY MEDICAL EXAM	AINER)		
	MEDICAL	20c. TIME OF INJURY Month, Do	ay, Year 20d. INJ While		PLACE OF INJURY (Home, farm, 20f. (City or town) (Caunty) (State) factory, street, office bldg., etc.)
	MEC	p. m	19 at work	140f Willie	0
		21. I certify that (I) (this ha	spila) attende	d the deceased from	00 1960, to fless 3d, 1961, that (1) (we) last
		saw the deceased alive an	Jan 2	4 196/, and that	death accurred of 30M, from the causes and on the date stated above.
		720 AGNATORE	1	1	ATTENDING MED CTAFF 22b.DATE SGONED
		Wylena	peus	res	M.D. ATTENDING MED DIRECTOR STAFF PHYS. 1/30/61
		22c PHYSICIAN'S NAME (Type)	7		22d, ADDRESS
					westmenster hed
	230	BURIAL, CREMATION, 23b. DATE REMOVAL (Specify)	THEREOF	23c. NAME OF CEMETERY	OR CREMATORY 23d LOCATION (City, town, or, caunty) [Stots]
	/	wit 2/2	161	Levelor	- Cemelley King Westhimple By
	24	ENNERAL DIRECTOR'S SIGNATURE	0 60	ADDRESS	250 REC'D BY REGISTRAR 251 REGISTRAR'S S GNATURE FFR 1 '61 CATHUR A THOUSA
	1	1. Simply	A 1/100	1 permaler	DATE FELS I DI CINCIA Z. MAIN
	/				

VR A15 (4) 15M 9/59



AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) slay is necessary, and director. Page of for your files. Board of Health, a. COUNTY **b.** COUNTY Bal to City Marvland Carroll MARYLAND b. CITY OR TOWN (if oulside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town] Baltimore Svkesville yrs.umos.15days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS 6. IS RESIDENCE ON A FARM? retained he State YES TO NO Bevans St. Springfield State Hospitel 4. DATE Middla DECEASED OF the th 3 to ta (Type or print) DEATH 1967 in pencil in Item 18. Give Pages 1, 2, and 3 to 4. Office along with form PM3. Page 5 may be reurial-transit permit. File pages 1 and 2 with the movel, and jn any event within 72 hours after Harry Vanlusen January 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 5. SFX 9. AGE (In years HE UNDER 1 YEAR IF UNDER 24 HRS. lest birthday) Months Hours DIVORCED WIDOWED I Male 60 yrs. 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 10a. USUAL OCCUPATION (Give kind of work 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if ratired) Unknown Alien Unknown - none -13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Unknown Unknown 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. 1 17. INFORMANT Address (Yes, no, or unkown) (Ifyasgivawarordalasofsarvica) Springfield Hospital Records. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c),] INTERVAL BETWEEN ONSET AND REATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO removal, Conditions, if any, which ease execute the certificate, writing the word "pending" should be forwarded to the Chief Medical Examiner's C FUNERAL DIRECTOR: Page 3 should be used as a brits designated agent, prior to burial, cremation, or rem gava rise to immediata causa DUE TO (a), stating the undarlying PART II, OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY CERTIFICATION PERFORMED? Mental deficiency, idiopathic, severe. NO 20b. DESCRIBE HOW INJURY OCCURED, (Enter nature of Injury in Part I or Part II of Ilem 18.) 20e. EXTERNAL CAUSE WAS PRIMARY | or CONTRIBUTING | CAUSE OF DEATH. 20c. TIME OF INJURY 20d, INJURY OCCURRED | 20s. PLACE OF INJURY (Homa, form, ' 20f. (City or town) Month, Day, Year (County) (State) factory, street, office bldg., etc.) While Not While Hour e.m. at work at work 21. I certify that I took charge of the remains described above, held an Autopsy Inspection V Inquiry and in my opinion death resulted from-Natural causes Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL ASSISTANT MEDICAL EXAMINER DATE SIGNED SIGNATURE DEPUTY MEDICAL EXAMINER EXAMINER'S James T. Marsh. NAME (Type) Address (Street, city, lown, of county) DEF -CREMATION, 226. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or country) BURLA REMOVAL (Spacify) 940 6 FUNERAL DIRECTOR ADDRESS VS. A15ME ⁷61 5M 7/99

MARYLAND STATE DEPARTMENT OF HEALTH



e IS RESIDENCE ON A FARM? YES NO

Hours

INTERVAL BETWEEN ONSET AND DEATH

hours

hours

vears

(County)

Ciring S. France

PERFORMED? YES NO F

(State)

22b DATE SIGNED

Year

19 67

0 **VR A1S (4)**

DIRECTOR:

FUNERAL

completely

pup

physician

attending

gned



479

C0477

1.	a. COUNTY Car	roll		MARY		d. STATE Maj	NCE (Where dece		ONMIC		before adm	ission)
	b. CITY OR TOWN (I RURAL and give no Sykesville			ength of Stay yrs15day	11	e. CITY OR TO Baltin	OWN (If autside co	orporate limits.	write RU	RAL and giv	re nearest to	wn}
	OR INSTITUTION	TAL (If not in hospitol, g		•		d. STREET AD	Alameda	-	3 V	11-	ON	ESIDENCE A FARM? NO 🔼
3.	NAME OF DECEASED (Type or print)	Clar		Wiehlen	ń	Wagner	4 DA OF DE		Monti	h	15°′	19 ^{Yeo} r61
	sex Female	6 COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIE		Unknown	n	9 AGE (I	n yeon		YEAR IF JN lays Hour	
100	during most of work Candy dipp	ON (Give kind of work of king life, even if retired)	done 10b KIND	OF BUSINESS O	R INDUSTR		CE (State or fore) a ryland	gn country)		1	OF WHAT	COUNTRY
13.	FATHER'S NAME					14. MOTHER'S A						_
_	Abrah						Piffer					
{Ye		R IN U. S ARMED FOR (If yes, give wor or doles of so	ervice)	al security no. 14-6260		spital :	records	Sylkles	Addre Vill	e Marj	yland	
CATION	Conditions, if o gave rise to i cause (a), stoting lying couse lost,	mmediate (Genera:	osclerot	ic He	oscleros	sis	EASE CONDIT	ION GIVE	EN IN PART	PERI	ID DEATH
CERTIFI	20a. ACCIDENT WAOR CONTRIBUTING	AS UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER)	206 DESCRIBE	HOW INJURY OF	CCURRED.	Enter nature of	injury in Part I or	Port II of item	18.)		123	
MEDICAL	20c. TIME OF INJUR Hour a.m. p. m.	Y Month, Doy, Yes	While	Y OCCURRED Not while at work		E OF INJURY (H ry, street, office	ome, farm, 20f. bldg., etc.)	(City ar town)		(Co	unty)	(State
		at (I) (this haspital		1 100		III-		ta 1-15 am the cau			., that (I) date state	
	22a SIGNATURE	Course	di	Hedu	L.M	ATTENDING	MED DIRECTOR	STAFF			1-3	226 DATE
	22c PHYSICIAN'S NAME (Type)	Raymond	Cladue			Spring	field St	ate Hos	pita	1.Syk	esvill	e,Md.
23	BUR AL, CREMATIC REMOVAL (Specify)			Moreland		Pk.		Balto.	Md.	.,		rate)
24	SULUDIO	S SIGNATURE A	lond	ADDRESS 2024	4 Orle		250. REC'D BY REDATE JAN 1 9			TRAR'S SIGN		

TO HOS: TOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 may be invined by the haspital ar attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled page 3 stoud be detached far use as the bur of transit permit. Then please removes action appears. Pages 1 of the State Board at Health prior to burial, cremation, or remayol, and in any event, within 2 hours after == th

i by the funeral director, and 2 should be filed with rs after death. Page.4

h .

tours after | mith

VR A15 (4) 15M 9/59



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

480

60478

1	PLACE OF DEATH	rroll		MAR	rland	o. STATE	ence (w		Eved. If instituti b. COUNTY		before od	
F	6 CITY OR TOWN (f outside corporate limi	ts, write	c. LENGTH OF STAY	IN Ib				ate limits, write R			
ı	RURAL and give no	SVILLE		15yrs.Lmc	23	lave R	eltin	more 26		RV	1 -	. 🐪 🔻
-	d. NAME OF HOSPIT	AL (If not in hospital, g	pve street d	address)	اريود	d. STREET A		1010 20				RESIDENCE
ı	OR INSTITUTION	ngfield St	ate H	ospital		3	619 F	Everett	St.			NO D
3	, NAME OF	Fir	*	Middle	1	Last	<u> </u>	4. DATE	Mar	n th	Day	Year
	(Type or print)	Mar	v	F.		Waldman		OF DEATH	Januar	ייי	22,	1963.
5	SEX	6. COLOR OR RACE		IED NEVER MARRI		DATE OF BIRTH	•	1	9. AGE (In years	IF UNDER 1	YEAR IF UI	NDER 24 HRS
ı	Female	White	WIDOWE	D DIVORCE	D TC	May 28.	1911		last birthdoy) 19 yrs	Months (Days Hou	irs Min
Ī	Do USUAL OCCUPATIO	ON (Give kind of work	done 10b	KIND OF BUSINESS O	OR INDUST			or foreign co	untry)	12.CITIZ	EN OF WHA	AT COUNTRY?
1	Practical	king life, even if retired NUTSE	'	_		Mar	yland	đ		U.S	5.A.	
ī	3 FATHER'S NAME					14. MOTHER'S	MAIDEN	NAME				
1	Junious T.	Clark				Mar	garet	t McGar	rity			
楦	S. WAS DECEASED EVE	RIN U. S ARMED FOR		SOCIAL SECURITY NO). 17 INF	ORMANT			Ado	ress		
Г	No No	(If yes, give war or dates of s	esasce]	-		Spring	field	d Hospi	tal Reco	ords		
		mmediate (Mit Rhe	cral stenos	sis	isease						
	Schizoph	HER SIGNIFICANT CON	an oid	type.						VEN IN PART	PE	AS AUTOPSY REORMED?
		AS UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER)		CRIBE HOW INJURY O				,				
1	20c. TIME OF INJUI Hour a.m. p m.	Y Manth, Day, Ye 19	While	Not while at work		CE OF INJURY () Dry, street, office			or fown)	(C	ounty)	(Stote)
	saw the decea	ut (I) (this haspital sed alive an Jai										
	226. SIGNATURE	stin de	cf (Emipo	M	D. ATTENDING		AED.	STAFF PHYS		1/2	22b. DATE SIGNED 3/61
	NAME (Type)	Igustin de	1Camp	o, M/D.				ld_Hosp	ital,Syl	kesvil	le,Md,	
7		ON, 236, DATE THEREC)F	23c NAME OF CEN	ETERY OR	CREMATORY		23d LOCAT	ION (City, town,	or county)	- (State)
	Burial (Specify)	Jan. 25	, 196	1 Holy Cr	coss C	emetery		Ritch	ie Hwy,	A. A.	Co-	Md
2	4. FUNERAL DIRECTOR	'S SIGNATURE		ADDRESS			25o. REC	'D BY REGIST	RAR 255, REG	ISTRAR'S SIG	NATURE	
	FLYNN &	FLEMING, I	NC. 1	422 Light	St.		DATE 1	AN 2 4 16	1 0	77 - 0	40	

the attending physician and completely filled $\overline{\mathcal{M}}$ by the funeral director. Then please remove carbon papers. Pages 1 and 2 should be filed-with may by vined by the hospital or attending physician.

TO FUNI — DIRECTOR: After this certificate has been signed by the attending physician and completely filled to page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. TO HOS VR A1S (4) 1SM 9/59

2"

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24.

Pars after death. Page 4



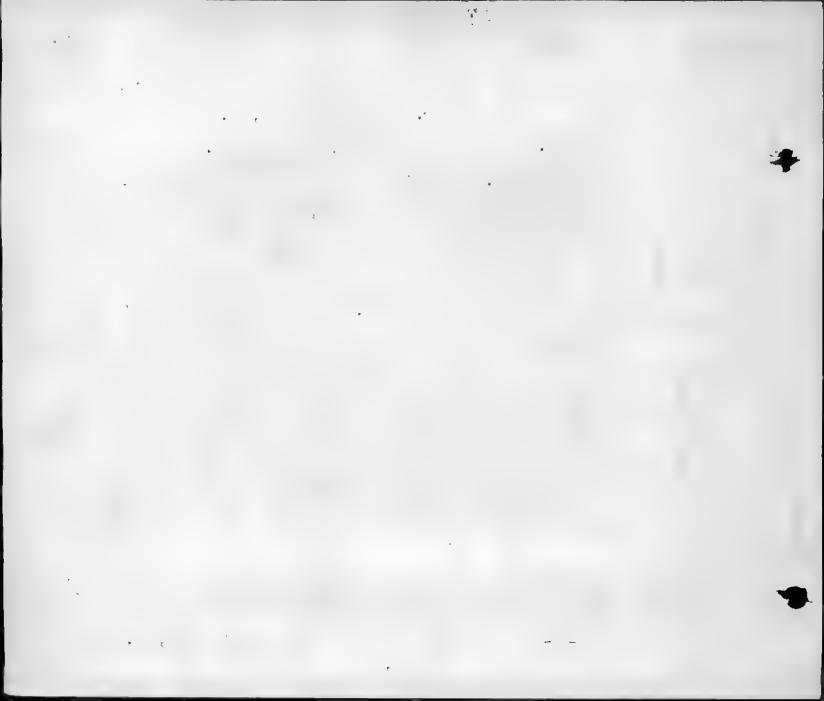
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 48 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

60479

Reg. Dist. No.

	LACE OF DEATH		-		2. USUAL RESID	ENCE (W)	here deceased liv	red If institut	ion Residence b	refore admission)
°	Carrol	1		MARYLAND	Maryla	and		b. COUNTY	arroll	
Ь		autside corparate l'mits will	RURAL	c. LENGTH OF STAY IN 16			outside corporati		RURAL and give	neorest fown)
1	Westminks			5 yr.	Westmir	ixs te	r. Md.	(d.)	1	
d	NAME OF HOSPITA	AL OR INSTITUTION (f not in hoss	oital, give street address)	d STREET AD		-3			ON A FARM
	109 East	Main St.			109 E	Gast_	Main St	. 1		YES NO 5
	IAME OF	Fir	n\$	Middle	Last	1	4. DATE OF	Month	Do	y Yeor
	Type or print)	Helen	E.	Watkins			DEATH	Januar	y 16	1961
5 . St	X	6. COLOR OR RACE	7. MARRIE	D NEVER MARRIED 8	DATE OF BIRTH		9 A	GE (In years It birthday)	IF UNDER TYEA	
	Female	White	WIDOWED	DIVORCED [March 2,	1880			Months Days	Hours Min
10a.	USUAL OCCUPATION	ON (Give kind of work or life, even il retired)	done 10b K	IND OF BUSINESS OR INDUST	RY 11 BIRTHPLAC	E (Stote o	r foreign countr	у)	12. CITIZEN	OF WHAT COUNTE
	Housewife	g life, even il retired)		No	Mary	rland				USA
13.	FATHER'S NAME			·	14. MOTHER'S M	AIDEN NA	AME			^
B	asil Buxto	on			Charl	Lot te	Brande	nburg		
	WAS DECEASED EVI	ER IN U. S. ARMED FO		SOCIAL SECURITY NO. 17. II	PORMANT			Address		
	no	(, /		no Mr	s. Lucy	Swart	tzbaugh	Same	as 2	
	18 CAUSE OF DEAT	TH [Enter only one cou	se per l'ne f	or (e), (b), and (c)]		2	· · · · · · · · · · · · · · · · · · ·		Tin?	TERVAL BETWEEN
	PART 1. DEAT	H WAS CAUSED BY		Verous,	11/-1	re	entra.	211		5- Les 2 7.
Н	42	DUE TO			7 1	1		1		otromist.
	Conditions, if or	ny, which) (b)		arouter	4 SK	621	620	of X		10-12
	gove rise to immed	diote couse		11.1+	7					713
	(e), stating the cause lost.	(c)		ALKELLE	llzec	u _				1
	PART II. OTH	ER SIGNIFICANT CON	DITIONS CO	NTRIBUTING TO DEATH BUT I	OT RELATED TO TH	TE TERMIN	VAL DISEASE CO	NDITION GIVE	N IN PART I(o)	19. WAS AUTOPSY
Y1X										YES NO
CERTIFICATION	200. EXTERNAL CAL	JSE WAS 20	b DESCRIBE	HOW INJURY OCCURRED (E	nter nature of injur	y in Port	or Fort II of ite	m 18.)		
25	200. EXTERNAL CAL PRIMARY or COP CAUSE OF DEATH.	AIKIBUIING LJ								
3	20c. TIME OF INJUI	RY Month, Doy, Ye	or 20d. 1	NJURY OCCURRED 200 PLA	CE OF INJURY (Ho	me, form,	20f. (City or le	own)	(County)	(Stote)
VEDICAL	Hour g, m,	19	White at war	Not while	ory, street, office bi	idg., etc.)				
	21. I certify th	ot I toak charge	of the r	emoins described obo	ve, held an A	utopsy	Inspe	ction X.	Inquiry	7, ond in m
		resulted from:	,-			_ ` .			mined mann	
П	1.	11.		3, 7,		L-4/		, ondere.	THE STATE OF THE S	
	ACTUAL (THILIX	10	relies of	M.D CHIEF MEE	DICAL EXA	MINER			DATE SIGNED
Н	SIGNATURE -	1 - Color	2423			MEDICAL	L EXAMINER [,	1/1///1
	EXAMINER'S NAME (Type)		1	lete	CCO DEPUTY MI	EDICAL EX	LAMINER PO		- /	116/6/
220	BURIAL, CREMATIO	IN 7226. DATE THEREC	OF T	22c NAME OF CEMETERY OR	-		27d LOCATION	(City, town, o	r county)	(510te)
	REMOVAL (Specify)	1-18-61		Montgomery			Clagett	erille.	Md.	
23	FUNERAL B. RECTOR	SIGNATURE		Montgomery /	24	to. REC'D	BY REGISTRAR		TRAR'S SIGNAT	URE
1	somis -	4.53 ante	Layt	consville, Md.	C	ATERAN	1 9 '61			
1						- VAIX	3-01-	Cixt	Ling S. Has	-

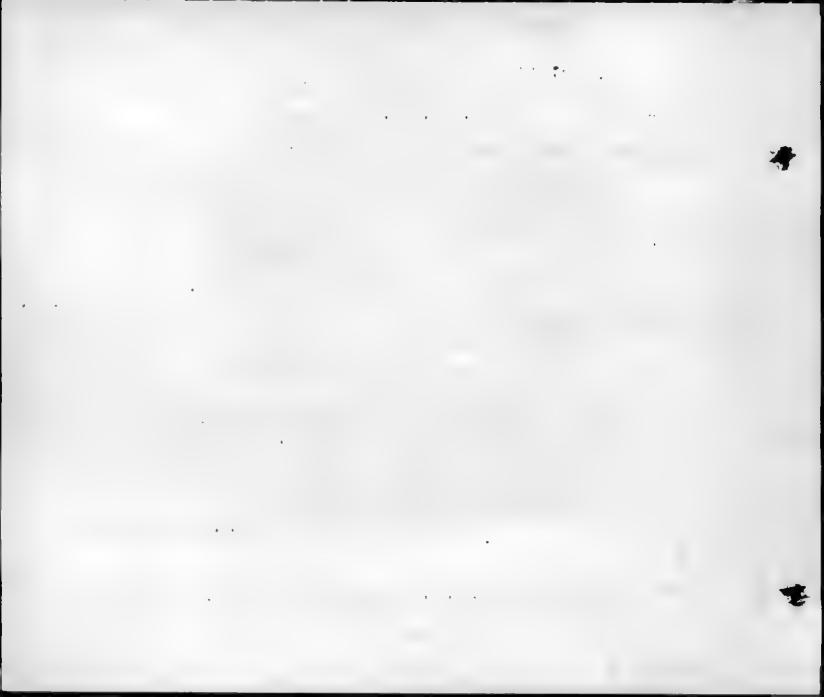
TO DEPUT SELICEL EXTININER: This centrinate thauld be executed within 24 haurs after death. If any delay a execute execute (extiticate, writing the ward 'pending' in penal in Item, IB. Give Pages 1, 2, and 3 to the fact should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be related FUNERAL DIRECTOR: Page 3 should be used as a bunial-transit permit. File pages 1 and 2 with the State or its designated agent, prior to burial, cremation, ar remayal, and in fay event within 72 hours afterwareath VS A15ME 5M 2'57

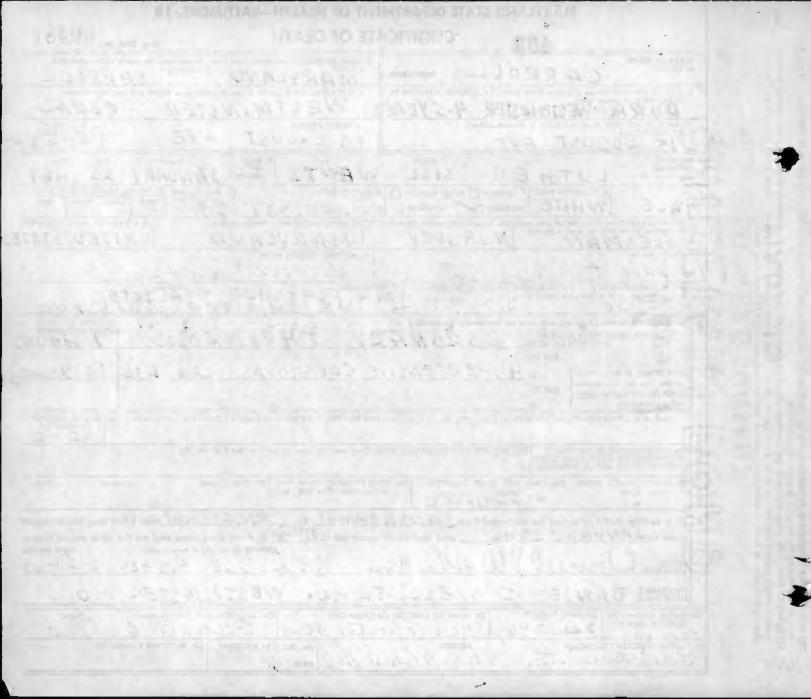


MARYLAND STATE DEPARTMENT OF HEALTH Sign of Statistical Research and Records — Baltimore 1, Maryland CERTIFICATE OF DEATH

00480

47 .	_	_		CERTIFIC.	AIL OI DEAIII	0 1011
ge	3 /			LACE OF DEATH	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before	e admission)
Pog direct	filed (N	1 0	Carroll MARYLAN	Maryland b. COUNTY	~
eath.			<u> </u>	. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1		rest town)
deo	φ P		R	RURAL ond give necrest town) iralSykesville 6y. 10m. 27d	Baltimore	
ofter the f	plnots			I. NAME OF HOSPITAL (If not in haspital, give street address)	d. STREET ADDRESS	IS RESIDENCE
N A	2 6	15	S	oringfield State Hospital	3023 Abell Avenue	YES NO
3	0	1	3	First Middle	Lost 4. DATE Month Day	
in 24 filled	a to			Type or print) Agnes Ellen	Weaver DEATH I II	1961
ithi ely	ရှိ မို		S. 5	MORRIED		Hours Min.
N de	offe offe			female white WIDOWED D DIVORCED	11/7/69 das pyrindoy) Months Doys / C	1.0013
scuted	ape		10a	USUAL OCCUPATION (Give kind of work dane 10b, KIND OF BUSINESS OR IN during most of working life, even if retired)	DUSTRY 11 BIRTHPLACE (Slote ar fareign caunity) 12 CITIZEN OF	WHATCOUNTR
e exe	- 2/			Housewife	Pennsylvania USA	
		1	13.	FATHER'S NAME	14. MOTHER'S MAIDEN NAME	
ficote t	2 E			Rolandus Gross	Seifert	
tific	, Š .	7		WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. no. or unknown) 1 (If yes, give wor or dates of service)	INFORMANT Springfield Hosp. Address	
rec g	ever .		[(0)	tryes, Quee ear or ourse or service)	records Sykesv	ille, Mo
ooth ndir	eose ny (18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTE	RVAL BETWEEN
of de	اعاد			PART I. DEATH WAS CAUSED BY:		et and death Davs
4 2	lher nd			IMMEDIATE CAUSE (6) Bron Chopine Union	114	107 D
thod by	, ± = =			Antoniogolono	tic heart disease	Years
Se P	rmi			gave rise to immediate	ore heart disease	[Caro
in by	# E			Company and	riosclerosis	rears
K re	onsi of		z			
hysical s	tion ti		ATIC		ut not related to the terminal D. Sease Condition Given in Part 110) 15 th circulatory disturbance, with	PERFORMED?
The ig p	i Pari	3	IFIC	cerebral arteriosclerosis with psychology Accident was imperious 12 206 Describe how injury occur	OTTIC PROCETION. RRED. (Enter nature of injury in Part I or Part II of item 18.)	715 1131 110
IAN: endin	the b		. CERT	20g ACCIDENT WAS UNDERLYING [] 20b DESCRIBE HOW INJURY OCCUI OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	,	
SIC	SO CO		MEDICAL		PLACE OF INJURY (Home, form, 20f. (City or town) (County) foctory, street, office bldg, etc.)	(Sto
E Sign	5 5		MED	Hour c. m. p. m. 19 While Not while of wark of wark	Totally, street, office stag, etc.)	
5 1 gg #	roi			21. I certify that (10) (this haspital) attended the deceased frai	n 2/20/ 1954 to 1/17/ 1961 the	at 05 (we) ic
Pig Pig Afi	the d			saw the deceased alive an 1/17/ 1961, and that	n 2/20/ 1954, to 1/17/ 1961, the t death accurred at 11:00 from the causes and an the date	stated abov
TE + Pe - C - C - C - C - C - C - C - C - C -	eal	Z.		22a SIGNATURE //a/) + + + Mall	deall decorred diseases and all the date	22b.DATE
P P	of d	/		KO111/41414 /12000	M.D PHYS. DIRECTOR PHYS	SIGNI
ned Direct	d b			22c PHYSICIAN'S	22d ADDRESS Springfield State Hospital	1
	Pov Box			NAME (Type) Konstantin Weber, M. D.	Sykesville, Maryland	
HOSP oy be re	3 s tote		230	BUR AL CREMATION, 236. DATE THEREOF 23c NAME OF CEMETER		(tote)
*	× -		6	Bernel Jan, 20,1961 Streem	nount york york C.	Pa.
5 E	0.2		24.	PUNERAL DIRECTOR'S FIGNATURE ADDRESS	250 REC'D A REGISTRAR 26. REGISTRAR'S SIGNATUR	₹E
VR A1S				acol Hartenatein New Fronds	M. Pa. DATE JAN 20 '61 Cuthun & three	a All
1SM 9/	59				The state of the s	A.F.





48 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 4 shauld be cremation, PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) D. STATE b. COUNTY Carroll Maryland MARYLAND b. CITY OR TOWN (If oviside corporate limits, write RURAL c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17yrs.8mos.19days Sykesville Baltimore 17 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS Springfield 1700 Eutaw Place State Hospital 3. NAME OF DECEASED 4. DATE OF DEATH First Middle Month Edna Wolf May (Type or print) January 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 2 8. DATE OF BIRTH 5. SEX . 9. AGE (In years 55 1 2 with th Female White June 22, 1905 WIDOWED [7 DIVORCED [] ym. 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) NOTE:

NOTE: Many 17. 200. 1 Maryland Page 5 may 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME Edward Wolf Mary List 15. WAS DECEASED EYER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address No Give Springfield Hospital Records EDICAL EXAMINER: This certificate should be executed -ithin 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).

e. IS RESIDENCE ON A FARM?

YES NOT

Yeor

IF UNDER 24 HRS.

1961

Reg. Dist. No.

Balto City

Day

12. CITIZEN OF WHAT COUNTRY?

INTERVAL BETWEEN

24.

U.S.A.

IF UNDER TYEAR

Months

E L			PART I. DEATH WAS CAUSED BY MAMEDIATE CAUSE (0) Coronary thrombosis	Hours
ith fo			420. / DUE TO	1
along w	+3		Conditions, if any, which gove rise to immediate couse (a), stating the underlying couse last.	
s Office sed as	2	CATION	PART IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II Mental deficiency without psychosis.	(a) 19. WAS AUTOPSY PERFORMED? YES X NO
ominer		CERTIFI	200. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING D 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port II of from 18.) Patient fell out of bed, causing old scar on back of re-onen.	head to
dical Ex je 3 shot		MEDICAL	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or lown) (County Hour o. m. 1/2L/ 1961 at work of work 1 Hospital Sykesville Carr	
CTOR: Pag			21. I certify that I took charge of the remains described above, held an Autopsy X, Inspection X, Inquiry death resulted from: Natural causes X, Accident X, Suicide \(\), Homicide \(\), Undetermined cause \(\).	E, and find the
o the C			SIGNATURE SUCK I MEDICAL EXAMINER [DATE SIGNED
worked to UNERAL removal.	2		ASSISTANT MEDICAL EXAMINER TO DEPUTY DE	1/25/61
farwarded TO FUNERA or remove	1		BURIAL CREMATION, 226. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, lown, or county) PEMOVAL (Specify) 1/27/41 LURIPLINE CEMETERY OR CREMATORY BALLING RIP	(Stote) MD
A15ME(5) A 9/55	Å.	23	FUNERAL DIRECTOR'S SIGNATURE ADDRESS 240. REC'D BY REGISTRAR 246. REGISTRAR'S SIGN , F. EVANS I SON 118 W. M.E. ROYAL AVE DATE JAN 31'61 Civilian 8.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

LINE STATE SECOND Actor design to a contract of TO RESIDENCE TO SELECT OF SELECTION AND ADDRESS. The state of the s